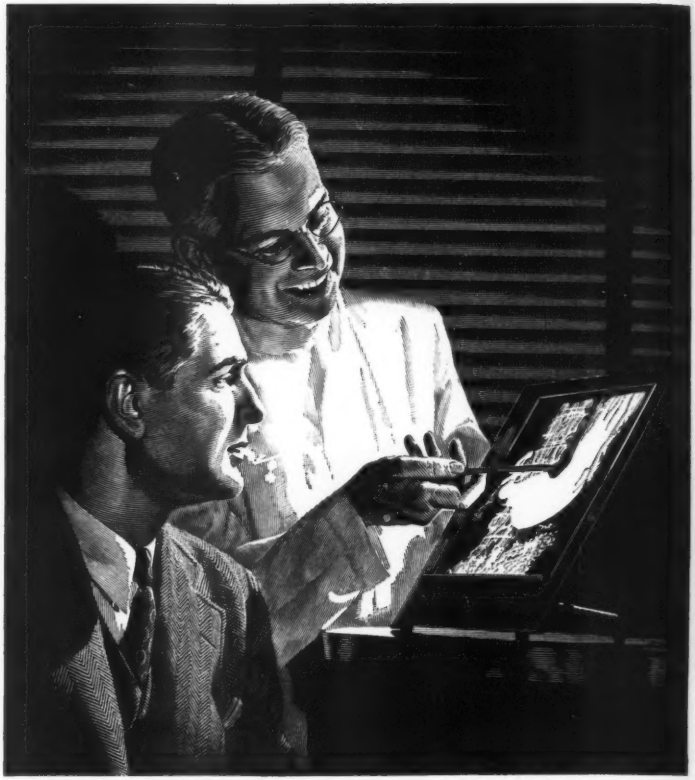
Medical Economics

SEPTEMBER 1944



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*WOLDMAN, E. E., and POLAN, C. G.: The Value of Colloidal Aluminum Hydroxide in the Treatment of Peptic Ulcer; A Review of 407 Consecutive Cases, Am. J. M. Sc. 198: 155-164 (Aug.) 1939.

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Medical Economics

THE BUSINESS MAGAZINE OF THE MEDICAL PROFESSION

SEPTEMBER 1944

Cover by Medical Photo Service

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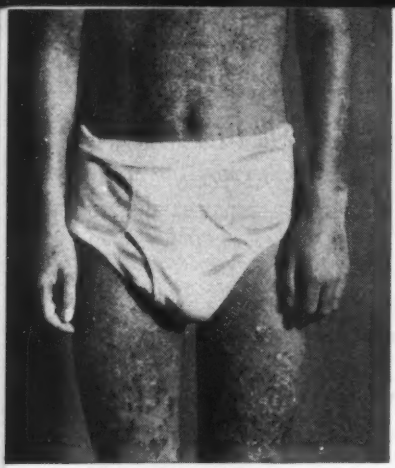
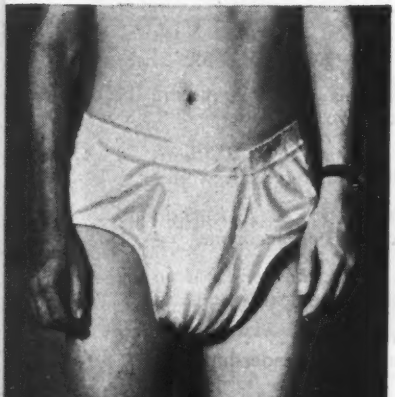


Before Use of Riasol



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Speaking Frankly

Student Supply

Regarding AMA criticism of Government policies concerning the supply of medical students, I have this to say:

1. The U.S. still has more doctors in relation to population than any other country.

2. Our problem has long been poor distribution rather than an inadequate supply.

3. As medicine advances in the field of prevention, fewer physicians will be necessary.

4. The cry for more students comes from medical schools (that can't exist without them) and from hospitals (that would like to maintain their staffs of unpaid help). This is shortsighted and selfish.

5. If we drift into socialization of medicine an oversupply of doctors will be a convenient excuse for Federal administrators to lower the incomes of physicians.

M.D., New York

I think the War Department's decision to curtail the number of men assigned for medical training is wrong. The schools will suffer in the long run, since the 4-F's left will not be so well-qualified in premedical training.

M.D., Texas

The Selective Service policy of no deferments for medical students can only work harm. The claim of the Army that it needs these men to fight is nonsense. Look at the number it immobilizes in service commands in this country—far more than the 6,000 to 8,000 who could be deferred for medical training.

M.D., Illinois

Medical trainees should not be deferred. I know of three rich young men who suddenly decided on a career in medicine—to avoid the draft.

Theodore P. Murphy, M.D.
Montpelier, Vt.

When Dean Lewis was president of the AMA he said, "There are 25,000 too many doctors in the U.S." We are now getting along very comfortably. Twenty-five per cent of the run of patients are neuros, and they won't die through lack of treatment. Even as things now stand there will be too many physicians after the war. Draft the students and let 'em fight.

M.D., Vermont

I endorse the watch-and-wait attitude of Dr. Fred Zappfe, of the Association of American Medical Colleges. I don't think we should form opinions until we have all the facts. How many prospective students will there be this year among the discharged men of the Army and Navy? How many doctors will return to active practice this year and next year?

There are a great many persons

over thirty, neither service-discharged nor 4-F, who would like to enter medical schools. Some of them are capable persons who were turned away a few years ago because the schools were crowded.

C. P. Segard, M.D.
New York, N.Y.

We need fighting men more urgently than doctors.

M.D., Illinois

A 4-F rating doesn't necessarily imply unsuitability for medicine.

M.D., Illinois

We must win the war, and that means inducting every man who can help do it, regardless of what happens afterward.

Anna Zatlin, M.D.
Chicago, Ill.

I am not alarmed. We need fewer doctors, and better ones.

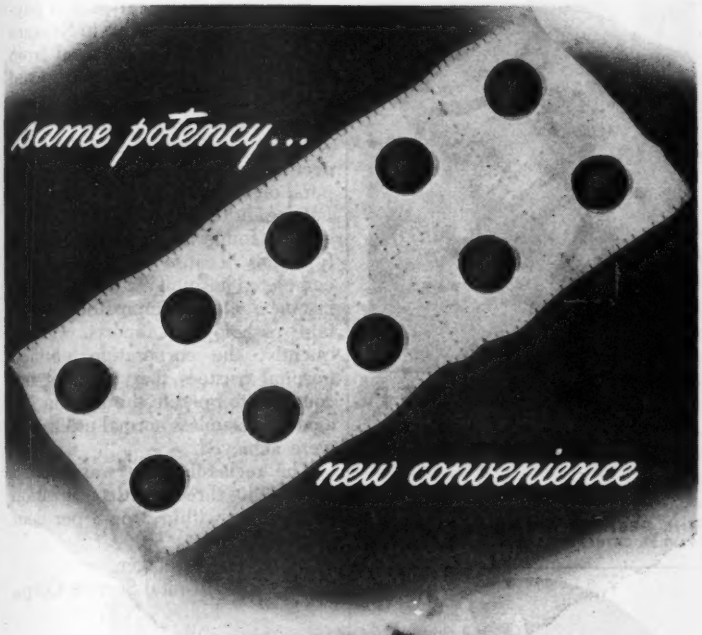
Eoline C. Dubois, M.D.
Springfield, Mass.

Denies Putsch

Dr. R. H. Sherwood, Niagara Falls, N.Y., recently asserted that the Western New York Hospital Service Corp. (Blue Cross) instigated a putsch against the medical profession in that city. The statement is not true.

It *is* true that a reclassification of physicians and their appointments in various services was carried out by the medical staffs of the hospitals themselves. But at no time did the service corporation attempt to influence appointments. As a matter of fact it does not know even now what privileges were granted to physicians in the area.

Here is the situation which led to the reclassification of physicians:



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In 1939 the corporation was paying out $1.17 to hospitals in Niagara Falls for every $1 it received from subscribers. Investigation showed that admissions and average length of stay of subscribers in that city were 50 per cent greater than the over-all average for all areas the corporation served.

In addition, the corporation frequently found it impossible to verify claims because doctors had not completed hospital records. In many instances, it was impossible to obtain pathological reports. Consequently, the corporation notified hospital trustees that it could not continue to operate the plan in Niagara Falls unless normal utilization were achieved.

The reclassification was carried out. Within three months utilization dropped to within 2 or 3 per cent of normal.

Carl Metzger,
Hospital Service Corp.,
Buffalo, N.Y.

Re-education

I can endorse the efforts of various groups in medicine to provide adequate post-graduate or refresher training for demobilized physicians, as described in your article, "Medical Education: Postwar." I was in service in the first World War and during the subsequent occupation of Germany, and did not return to civil life until 1922.

There is a vast difference between military practice and private practice. The physician in combat service is mostly a glorified first-aid technician, and the man in the hospital is a surgical specialist, since 85 per cent of military work is traumatic in nature. Consequently after the war the country may be flooded

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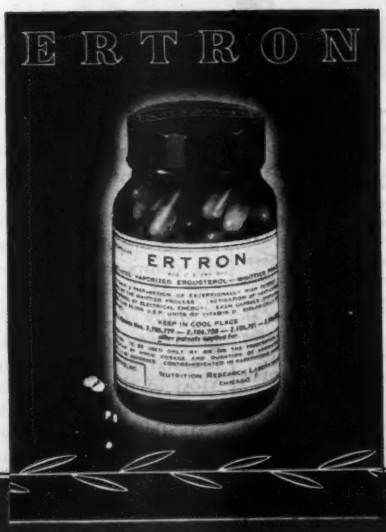


with surgeons and seriously short of general practitioners.

W. S. Bennett, M.D.
Granville, N.Y.

A lot of Federal aid for demobilized physicians would stimulate Government control of medicine. As a veteran of the last war, I found no difficulty in getting back into practice. Why should there be trouble now? It all depends on the man. Some not overly successful M.D.'s will, of course, need help; the really successful men won't. And if a man sold his equipment it was probably old and out-of-date. Why should he expect the Government to set him up with modern stuff?

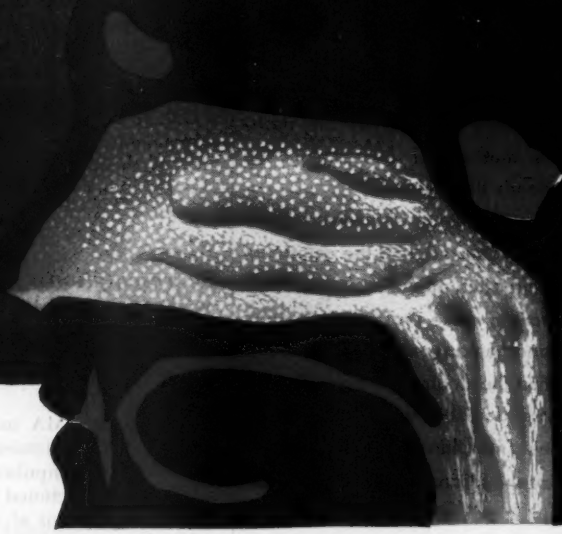
J. Lynne Goode, M.D.
Los Angeles, Cal.

The plans for additional training of demobilized young medical officers are commendable, and so are those for refresher courses for us older men. But we (especially the 40-to-50-year-olds who are "stuck" with captaincies by tables of organization) remember the plans of the Army to see that doctors were given better consideration than they received in the last war. So we thank you for your plans—with our tongues in our cheeks. We shall return to the competition of private practice and ask little.

Many of us, leaving lucrative practices, have seen non-military-minded men move in and take over. Most of these physicians will stay put and hang onto practices that we virtually gave them by volunteering.

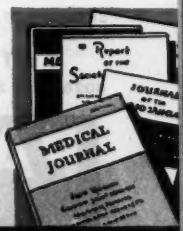
One more thing: Many of us who are rusty on new products are hoping that the pharmaceutical houses will prepare booklets or file cards on the new drugs and on changes

Suspension



(3) ***Therapeutic pH.*** The pH range of Paredrine-Sulfathiazole Suspension—unlike that of the highly alkaline solutions of sodium sulfathiazole—is slightly acid (5.5 to 6.5), and identical with the pH of secretions in the healthy nose.

In 191 cases reported in the literature, there was not a single instance of burning, stinging, hyperemia or tissue damage from the use of Paredrine-Sulfathiazole Suspension. *(Sulman, L. D., 1943; Silcox, L. E. and Schenck, H. P., 1942.)*



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and improvements in others, so that we can catch up quickly.

Medical Officer

One Reason

I have read the laymen's complaints listed in your survey article, "Why Patients Switch Doctors," and believe they are entirely misleading. After an active lifetime as a G.P., I am convinced that if the respondents were truthful, 75 per cent of them would have replied, "I owed him a bill that I would not pay."

M.D., Indiana

Representation

I think that physicians could achieve greater representation in the AMA, even within its existing structure, if the following procedure were adopted:

After each AMA meeting, prepare a digest of all issues considered.

2. Make it compulsory for delegates to hold sectional caucuses at which all questions of a controversial nature could be discussed (non-attending physicians could air their views by mail).

3. Limit voting at the next AMA meeting to issues that had been discussed locally everywhere.

H. E. Peterson, M.D.
St. Joseph, Mo.

Refrigerator

Perhaps some of your readers can utilize my solution to the problem of biological refrigeration:

I had a carpenter make an inexpensive, double-walled wooden case about 18 inches square. Outer and inner surfaces are about 1 inch apart, the space between them filled with fiber glass as insulation.

Now, about once a week, the lo-

cal druggist supplies me with a small bag of dry ice which has come packed around his biological and fountain supplies. At practically no expense, I keep my vaccines and sera well-preserved in a small corner of my laboratory.

J. Joseph Klar, M.D.
Springfield, Mass.

California Survey

I helped initiate the California Physicians Service and voted to endorse the findings and recommendations of the Foote, Cone & Belding survey. However, I take exception to the last sentence in their report which states that "There is at this time no national leadership seemingly competent to win through."

We have competent leaders—but too many of them are "from Missouri." They have yet to be shown—and the next job is to show them. A Foote, Cone & Belding survey of the entire country would, I believe, change their attitude. Facts permeate the medical mind slowly.

Paul A. Quaintance, M.D.
Los Angeles, Cal.

The CPS is just another example of too damned much medical politics. I attended the meetings prior to its establishment, and the way it was shoved down our throats was a disgrace. The CPS is now selling contracts to employed groups (teachers, city and county employes, and state employes), all of whom have sufficient income to pay for medical care at regular rates. The poor devil who makes $150 a month or less is not solicited.

M.D., California

The trouble with groups like the CPS is that subscribers expect to be

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BAYER ASPIRIN

given as much time as private patients. I feel that if the public demands prepaid service it should be made available as a Federal project, under the direction of physicians and minus the objectionable features of the Wagner bill. Given such a plan, we would be able to handle patients on a "production" basis, giving them speedy but efficient service. In that way physicians could be adequately remunerated and would not be expected to give the same personalized service they make available to private patients.

M.D., California

Remember that the survey was made in California—a state that puts the chiropractor and the osteopath on a par with the M.D., a state that overwhelmingly endorsed the Townsend Plan.

Present-day medical care is not inadequate but its adjuvants are. No person need be deprived of a physician's services; however, the physician is handicapped by lack of laboratory and hospital facilities. Correct this condition and there'd be no more thought of socialized medicine.

James Wagner, M.D.
New York, N.Y.

The best way to combat such a trend to socialized medicine is to reduce medical costs by providing more physicians and eliminating a great deal of laboratory and X-ray work. About two-thirds of it is unnecessary in the average case.

M.D., Oklahoma

Already large areas in medicine—prevention, public health, child hygiene—are socialized, because

[*Continued on page* 140]

Sidelights

Sadly in need of a handle is the movement represented by the country's voluntary prepaid medical service plans. Witness what the name "Blue Cross" has meant to the hospital service plans. Has any reader a short, descriptive name to suggest that would have a fair chance of catching on?

The method devised by the Public Health Service for measuring a physician's value to his community (see page 36) set us to thinking about our own doctor—whose capacity for service took a sharp drop when he found himself flat on his back in his own hospital, a casualty of the jammed waiting room and the frantic phones.

Our doctor is 52 years old. Only a brave man will tell him that the service he was rendering his community was 77 per cent of that given by his 40-year-old colleague.

The PHS makes it clear, of course, that its method of measuring service-capacities cannot safely be applied in today's hectic times. To that, amen! Capacity for service today, it seems to us, is limited by the doctor's ability to stand up and take it—and not by anything else, including his age.

Travelers from Russia tell us that the Russian burp has always been distinguished by a righteous and unabashed heartiness. We think we know why, after reading somewhat dubiously that Professor B. P. (no pun) Tokin of the University of Tomsk, U.S.S.R., has discovered that onions, leeks, garlic and similar redolent vegetables contain essential oils that kill bacteria, protozoa, yeast cells, and even the eggs of certain parasites. The Russians, no doubt, knew it instinctively all along.

We are still in the dark about the Russian sense of humor, though. Dr. Tokin's monumental finding was reported in a bulletin issued by the Soviet Society for Cultural Relations in Foreign Countries. We are happy to report that it does not have wide readership in the U.S.

Newspapers reporting a recent speech of Cornell's President Edmund E. Day managed to leave an idea that he had suggested an intermediate type of physician—one with more training than a trained nurse but less than a doctor of medicine.

Not so, says Dr. Day. His suggestion: that a sub-profession be developed to meet the greatly increased requirements of staff that are likely to come in providing adequate medical care and health services after the war.

"It seems clear to me," Dr. Day told MEDICAL ECONOMICS, "that we cannot expect to turn out enough M.D.'s to do all the job that lies

ahead, and that some of the less-exacting tasks of the expanded program will have to be carried out by technical personnel not so highly trained as is the modern doctor of medicine. An analogous situation seems to me to be developing in the field of engineering—in fact in all of the professional fields in which professional requirements are being constantly raised."

It's an interesting idea. But on the issues of training, income, and professional status of this newcomer, Dr. Day, unfortunately, has nothing to add.

Add Things That Were Bound to Happen:

Psychiatrists are having a field day in rejecting 35 per cent of the nation's 4-F's as psychoneurotics, said Christian Century, national Protestant religious weekly, in an editorial warning its readers that America is in great danger of exaggerating its mental ills.

"It is easy to believe," said the weekly, "that an undisciplined boy with a spoiled-child complex, an aversion to Army life, and a dislike for doing what he is told gets no help from having his tantrums or fears dignified into psychoneuroses or phobias, and learning to talk about himself in psychiatric terms."

Still easier to believe are the facts:

Service men with psychiatric disorders are being discharged from the armed forces at a rate of 30,000 a month. Total so far: more than 300,000. The good readers of Christian Century may now estimate what these figures might be if the 35 per cent of draftees rejected by psychiatrists had been inducted.

Editorial

Chance of a Lifetime

In many parts of the country, people have expressed their willingness to pay reasonable premiums for insurance against the burdens of illness. Yet the growth of voluntary medical service plans has continued to lag; no all-out effort has been made to sign up the millions who are presumably ready to buy such indemnity.

Principal reasons for the slow growth are: (1) There has been no central coordinating agency to facilitate the establishment of new plans. (2) The profession as a whole has not been, and is not yet, convinced of the inevitability of prepaid care.

For the moment, however, the outlook looks assuring. The AMA has come to the realization that action is necessary. Its Council on Medical Service and Public Relations has instituted a commendable ten-point program aimed at encouraging the growth of voluntary plans. It will act as a clearing house of experience; educate physicians to the necessity of prepaid care; be a liaison body with the Blue Cross; study private insurance plans and policies; scrutinize industrial and labor programs.

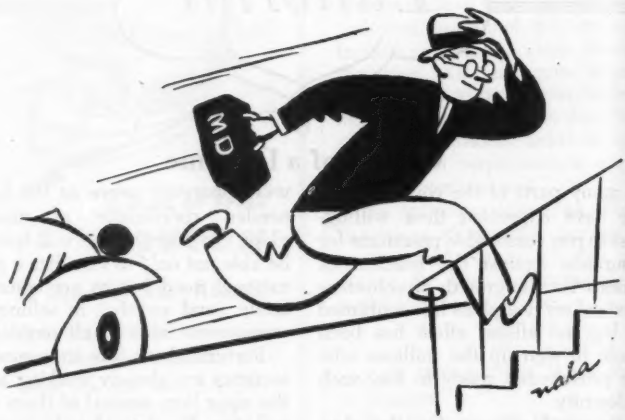
Most realistic step in the announced strategy calls for the employment of a director of medical prepayment insurance. This man will apparently serve as the badly needed coordinator of existing plans. To succeed, he will have to be able not only to visualize a great national need but to act constructively (and swiftly) in selling the prepayment idea to *all* physicians.

Fortunately, a few state medical societies are already working along the same line—several of them with full-time directors already engaged or about to be. But the number of such societies is small. Unless the majority of them provide the necessary funds and personnel for all-out participation in the movement, the AMA will be sorely handicapped.

This is medicine's golden opportunity—the chance of the century, no less. In fact, it is all the profession has to offer, since no single master plan is either available or advisable. Only by the spread of voluntary programs endorsed by local societies can prepaid medicine be kept from becoming a compulsory, Federal project.

Time is running out. Immediate teamwork is imperative. The American Hospital Association lent impetus and direction to the hospital plan movement. The American Medical Association should be able to do as much for medical plans—provided the state medical societies will back it up.

—H. SHERIDAN BAKETEL, M.D.



USPHS Devises Way to Measure M.D.'s Capacity for Service

Procedure is suggested as aid in estimating relocation needs

A fairly exact method of gauging the medical resources of a community is essential to intelligent relocation planning. Simple numerical counts of doctors fail to give a true picture. They overlook the relative capacity for service of local physicians, their expectancy in years of gainful employment, and the natural decline in efficiency associated with aging.

What's needed is a system of estimating resources which takes all these factors into account. The U.S. Public Health Service believes it has it. The new method, says the PHS, will

¶ Facilitate comparisons between areas;

¶ Define the needs of the understaffed community in terms of service rather than in numbers of doctors required;

¶ Establish a working basis for getting the right number of men into the right places.

Procedure has been worked out by USPHS Statistician Elliott H. Pennell. By correlating life expectancy and the known patient load at

each age level, he has evolved a "service equivalent" for the physician. This service equivalent shows the average doctor's capacity for professional work at different ages. It is thus a measure of the volume (not quality) of service that can be expected of him.

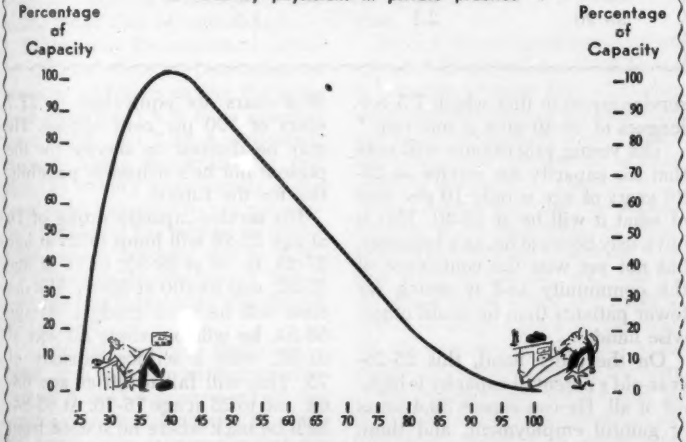
Pennell assigns the gainfully employed doctor of 39-40 years of age an arbitrary service capacity of 100. Patient-load studies show that at that age he serves more patients per week than at any other time in his career.

Patient-load figures are likewise used to determine the relative capacities for service of men above and below the 39-40 level. The doctor's life expectancy is also measured—first in remaining years, then in gainfully employed years, and finally in terms of full-service years.

This may sound complicated, but it isn't. All it means is that a gainfully employed physician of, say, 55-56 has a service capacity rating of 70 and a life expectancy of 17.8 years. Of these 17.8 years, only 15.9 will be years of gainful employment. And the 15.9 years, at that stage of life, will be equivalent to only 7.5 full-service years. In other words, the doctor at 55-56 can be expected to give his community, for the entire balance of his career,

Service Capacity of Physicians At Various Ages

Based on number of patients seen per week in 1942 by physicians in private practice



MEDICAL ECONOMICS

LIFE AND WORK EXPECTANCIES OF PHYSICIANS

Age of Physician	Life Expectancy in Years	Estimated Remaining Years of Gainful Employment	Estimated Remaining Full-Service Years
25-26	42.0	39.4	27.7
30-31	37.6	35.1	26.0
35-36	33.3	31.0	22.6
40-41	29.2	26.8	18.2
45-46	25.1	23.0	14.1
50-51	21.4	19.3	10.4
55-56	17.8	15.9	7.5
60-61	14.6	12.6	5.0
65-66	11.6	9.9	3.2
70-71	9.0	7.6	1.8
75-76	6.9	5.6	1.0
80-81	5.2	4.1	.4
85-86	3.8	3.0	.2
90-91	2.9	2.2	.0
95-96	2.1	1.4	.0

service equal to that which 7.5 colleagues of 39-40 give in one year.*

The young practitioner will note that his capacity for service at 25-26 years of age is only 10 per cent of what it will be at 39-40. This is obviously because he, as a beginner, has not yet won the confidence of the community and is seeing far fewer patients than he could otherwise handle.

On the other hand, this 25-26-year-old's potential capacity is highest of all. He can expect 39.4 years of gainful employment, and these 39.4 years are equivalent to 27.7 years of 100 per cent service. He may be shortest on service for the present but he's richest in possibilities for the future.

His service-capacity rating of 10 at age 25-26 will jump to 25 at age 27-28, to 50 at 29-30, to 75 at age 31-32, and to 100 at 39-40. His decline will be more gradual. At age 53-54, he will be where he was at 31-32, with a service capacity of 75. This will fall to 50 at age 63-64, and to 25 at age 75-76. At 83-84, he'll be back where he started from nearly sixty years before, his capacity for service having dropped to 10.

For purposes of illustration, con-

*In these calculations, as well as in those that follow, no attempt is made to consider the minor percentage of physicians in each age group who are not gainfully engaged in the practice of medicine.

sider an underserviced rural community with eight practicing physicians, distributed by age as follows: 29, 40, 50, 53, 59, 64, 66, 79. (This group is intended to reflect the preponderance of older doctors in rural practice.)

Applying patient-load statistics, we find the service-capacity ratings of these doctors to be, respectively: 59, 100, 81, 75, 61, 50, 45, 17. The eight men are equivalent, therefore, to only 4.88 full-service physicians.

If the community actually needs eight full-service physicians (it may not), it is then getting only 61 per cent of the medical attention it requires. It should have the equivalent of 3.12 additional full-service doctors—*e.g.*, three 40-year-old men plus one aged 25.

The shortage of 3.12 M.D.'s obtains of course only at the time the survey was made. If planning for the future is to make any sense, medical facilities a decade or two hence must also be considered.

In ten years the combined capacity of local doctors (assuming no losses or additions among the gainfully employed) will have dropped from 4.88 to 3.84—a reduction through aging equivalent to one man. In twenty years—really going overboard this time in our assumption that none has retired or died—their service capacity will be 2.39. Over the two-decade period, therefore, the loss in capacity will exceed 50 per cent.

While this example illustrates a point, it is patently an oversimplification. Actual measurement of the service-capacity of doctors in a rural community is complicated by several other factors. Most important of these is the high death and retirement rate in country practice (rural M.D.'s have a median age of 57 as compared with 44 for urban doctors). There are also such factors as the reluctance of new graduates to act as voluntary replacements in underserviced areas and the migration of rural doctors to urban centers.

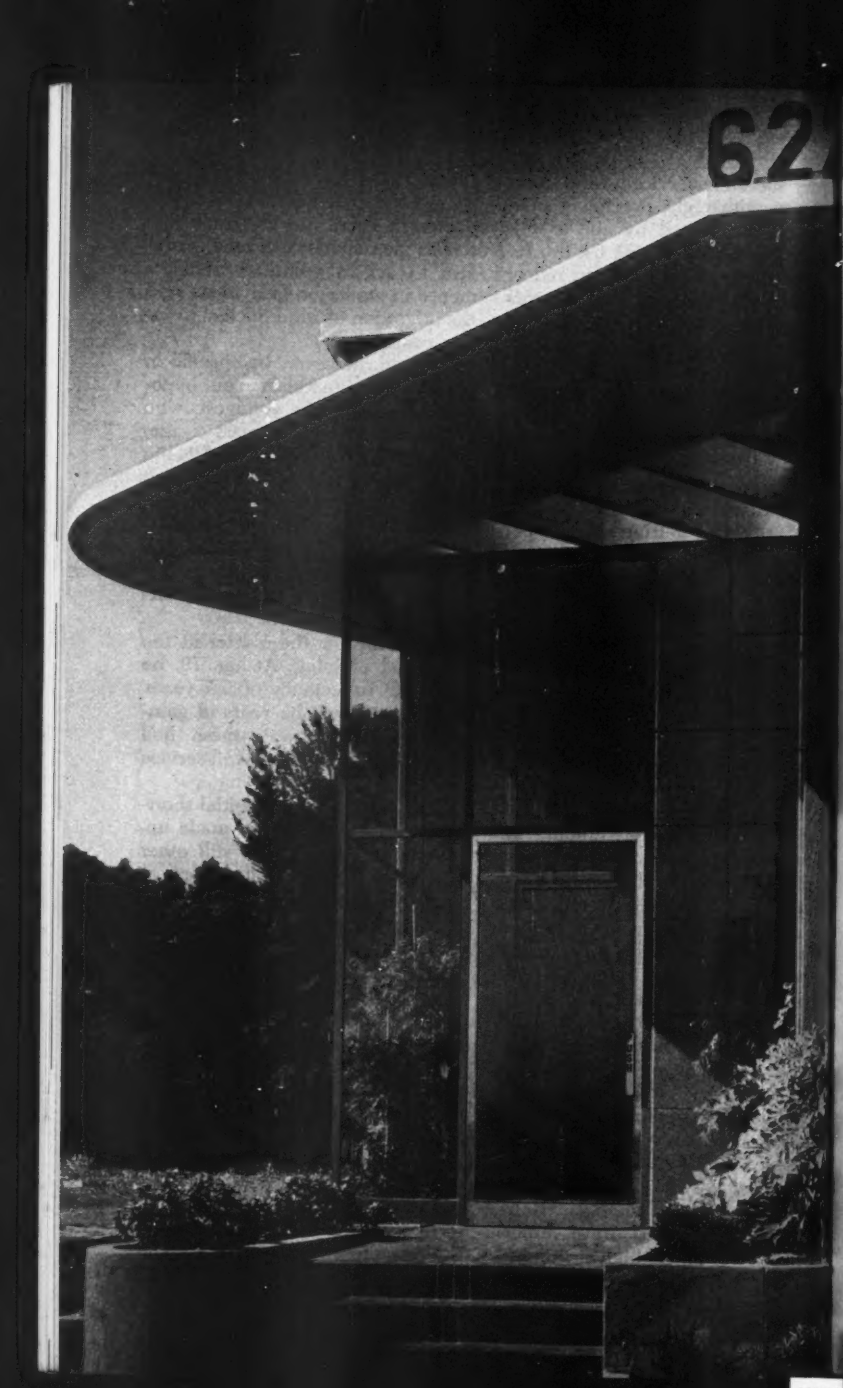
We can, however, be specific in considering individuals in our hypothetical group. The youngest, who is between 29 and 30 years of age, has a service capacity of 59. His life expectancy in years is 38.5, of which 35.9 will be years of gainful employment. The varying service-capacity indexes that will be assigned him during these 35.9 years, when added, give him a full-service expectancy of 26.6 years.

Let's see how the oldster at the other end is doing. At age 79, he has a life expectancy of 5.5 years. But only 4.4 will be years of gainful employment, and these boil down to 3/10 of one full-service year.

Even if the assumed initial shortage of 3.12 physicians is made up, it becomes evident that still other shortages will occur as the older doctors in the community begin to slow up. Frequently reappraisal of local needs is the obvious solution.

Any doctor may use the accompanying chart and table to determine approximately how these findings apply to himself, with the usual reservations about the application of average figures to individuals. He may also use the data to estimate the relative service capacity of the practitioners with whom he works. If he can determine the actual service needs of his community, he may even estimate the number of new men required to meet them.

—CLARENCE H. ROY



A Six-Man Medical Building

It may give you some good cues for that postwar office you're planning

Now housing a group of six Los Angeles specialists, 6222 Wilshire Boulevard may well be regarded as a pattern for the future. For one thing, it is compactly arranged for full utilization of land (it stands on a lot only 55 feet wide). For another, the designer—J. R. Davidson—has placed each facility with an eye to its relation with others. The six rooms for consultation and eight for examination are arranged in two groups: one for obstetricians, the other for pediatricians. A nurse's office and a laboratory serve as a hub for each group (see floor plan on page 45).

In addition, rooms have been provided for diathermy, fluoroscopy, and nose and throat examination.

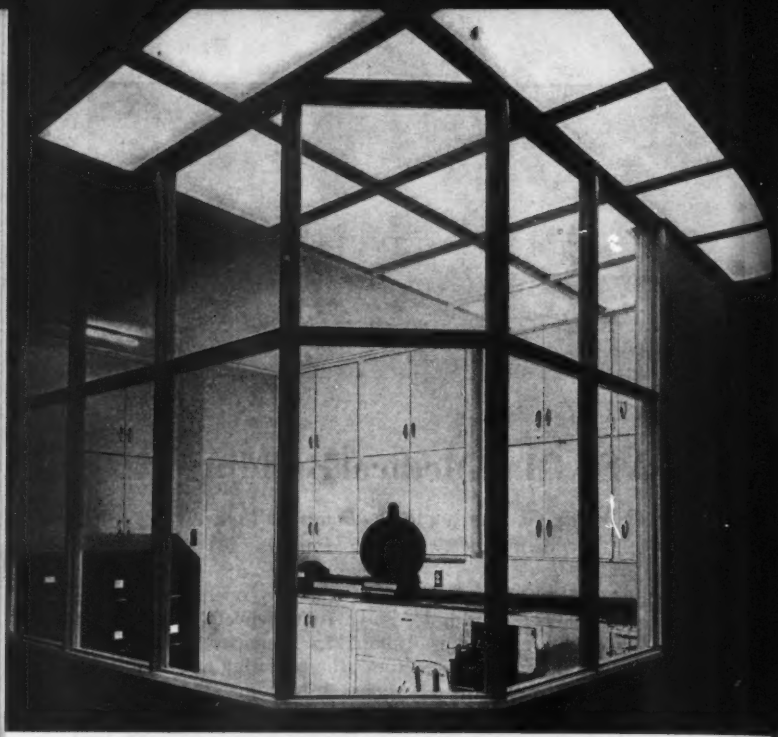
Although situated close to the boulevard, the building is well-insulated from noise and gasoline fumes, as well as from heat and cold. Ventilation is entirely mechanical, since none of the numerous windows (double-paned for insulation) is designed to open. Cold air is drawn from beneath the building, filtered, and pumped into the structure's three heating and ventilating zones. A coordinated exhaust system is located in the roof. In winter, three gas-fired furnaces heat the air.

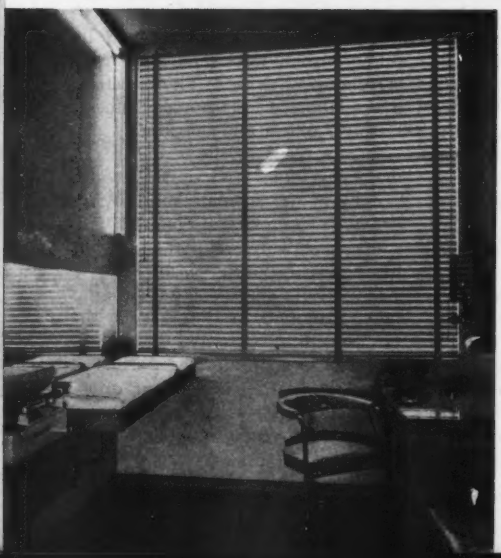
Natural lighting is achieved by numerous windows and an extensive system of skylights. These extend over laboratories, nurses' offices, business office, and corridors.

Inside walls of the structure, as well as its roof and outside walls, are thoroughly insulated and soundproofed. Ceilings are covered with sound-absorbing material, and walls finished with porous plaster on lath.

A parking space for patients has been provided in the rear of the building; the driveway leading to it passes directly under the portico of the main entrance (shown opposite). For other views of the building, see the pages following.

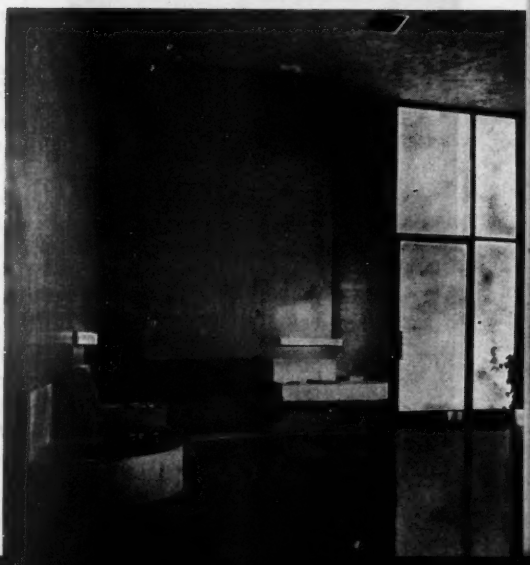
—GEORGE W. BROWNELL

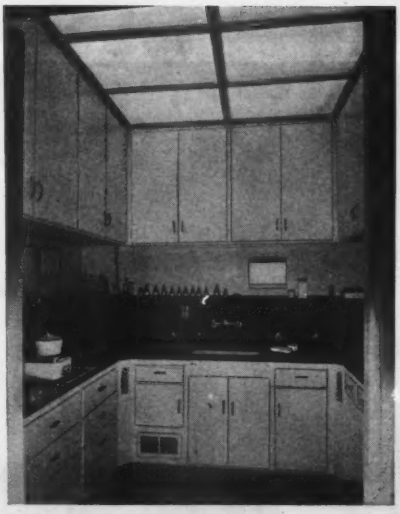




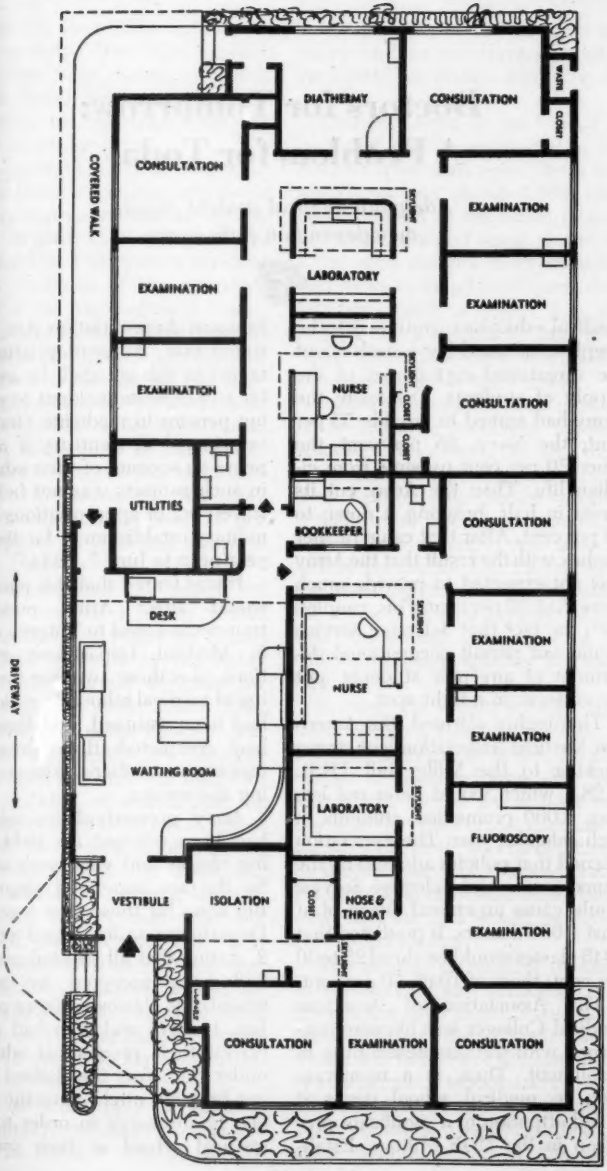
Above: One of the two nurse's offices. After dark, fluorescent lamps above the skylight provide ample illumination. Left: Pediatrician's examining room—typical of others in building.

Above and right: Reception room of the six-man building at 6222 Wilshire Boulevard, Los Angeles. Ceiling is of lightly tinted acoustical plaster, and walls of gray-tone oak paneling.



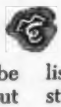


A covered walk leads departing patients to the rear parking space. The ports in its roof permit daylight to reach adjacent examination rooms. Left: One of the laboratories. There are two, providing separate facilities for each specialty. Business affairs are handled in a central office. An air of spaciousness is imparted to all rooms by their color scheme —light tints throughout with little or no contrast. All lighting (except in examining rooms) is indirect, and supplements a wealth of natural daylight.


DIATHERMY
CONSULTATION
WASH
CLOSET
COVERED WALK
CONSULTATION
EXAMINATION
LABORATORY
EXAMINATION
EXAMINATION
EXAMINATION
NURSE
SPUTUM CLOSET
CLOSET
CONSULTATION
UTILITIES
BOOKKEEPER
CONSULTATION
DESK
SPUTUM
EXAMINATION
NURSE
EXAMINATION
DAIRWAY
WAITING ROOM
LABORATORY
SPUTUM
FLUOROSCOPY
VESTIBULE
ISOLATION
CLOSET
NOSE & THROAT
EXAMINATION
SPUTUM
CONSULTATION
EXAMINATION
CONSULTATION

Doctors for Tomorrow: A Problem for Today

Adequate medical-student supply may depend on early peace



Medical educators continued to be deeply concerned last month about the threatened curtailment of the supply of students. Originally the Army had agreed to provide 55 per cent; the Navy, 25 per cent—the other 20 per cent to come from civilian life. Then the Army cut its quota in half, bringing it down to 28 per cent. After that came further slashes, with the result that the Army was not expected to provide much more than 20 per cent. This, coupled with the fact that Selective Service would not permit occupational deferment of any new students, put the colleges in a tight spot.

Thoroughly alarmed, the American Medical Association lent strong backing to the Miller bill (H.R. 5128), which would defer not less than 6,000 premedical students in each calendar year. The association warned that policies adopted by the armed forces and Selective Service would cause an annual deficit of at least 1,000 doctors. It predicted that 1945 classes would be sliced 25 to 30 per cent; those of 1946, 50 per cent.

The Association of American Medical Colleges was likewise concerned with the threatened drop in enrollment. Thus, in a memorandum to medical school deans it called attention to a significant provision in the 1945 Military Establishment Appropriation Act, which stated that "No appropriation contained in this act shall be available for any expense incident to educating persons in medicine (including veterinary) or dentistry if any expense on account of their education in such subjects was not being defrayed out of appropriations for the military establishment for the fiscal year prior to June 7, 1944."

It was feared that this paragraph would affect Army premedical trainees assigned to "interim duties" in Medical Department installations, plus those awaiting the opening of medical schools to which they had been assigned, and those who had completed their premedical training as civilians prior to entering the service.

Army premedical trainees who had been selected for 1944 entering classes and who were affected by the act numbered about 600. Big news for these men was a War Department order issued on Aug. 2, stating that all enlisted men who had been accepted by medical schools for classes entering prior to Jan. 1, 1945 and who had not received their premedical education under the Army Specialized Training Program might have the option of (1) discharge in order to enter medical school at their own ex-

pense or (2) immediate assignment to active duty. The order applied to October 1944 classes only—not to 1945 classes. Most students given the option of discharge were expected to accept it.

Perhaps the least disturbed view of the medical-student-supply problem was that expressed last month by Dr. Willard C. Rappleye, dean of Columbia University's medical school, chairman of the executive council of the Association of American Medical Colleges, and head of the Advisory Council on Medical Education. According to Dr. Rappleye, the situation was well under control. Medical colleges had little to worry about as far as their enrollment for the next two years was concerned. He estimated that they would be filled to at least 75 per cent capacity in 1945 and almost to that in 1946.

He denied that the supply of available medical students would be exhausted in 1946. Last month premedical students in the Army Specialized Training Program for 1945 numbered about 2,300. This, the Columbia dean figured, was sufficient to supply the medical schools with men for the next two years, provided, of course, that the Army did not pull them out of school and put them into combat units. School enrollment for 1945 fall classes would be derived, he said, as follows: 28 per cent from the Army, 31 per cent from the Navy, 19 per cent civilians, 5 per cent 4-F's—making a total of 74 per cent. He included no allowance for those in 1-C or for discharged service men who might be expected to return to civilian life.

The current supply of students, Dr. Rappleye estimated, would enable U.S. medical schools to continue operating at 110 per cent capacity and on the three-year plan until 1948 for classes currently enrolled.

Therefore eight classes instead of six would thus be graduated in the 1942-48 span of six years. Since this would provide about 7,300 men yearly instead of the 5,500 in normal times, the end result would be 1,800 extra doctors every calendar year, or more than 10,000 extra doctors from 1942 to 1948. "It is important to remember," he said, "that these 10,000 men will make a good reservoir for the future."

Rather than admit such boys of 18 as might be available, medical schools were advised by Dr. Rappleye to wait for returning service men. Failure to do this, he warned, would freeze out many competent demobilized veterans and show a lack of realization that 18-year-olds are often too immature to be ready for medical studies anyway. Moreover, he added, youngsters of 18 can be prepared quickly for military service.

A proposal supported by Maj. Gen. Lewis B. Hershey, director of Selective Service, to begin the discharge of qualified men who had seen active service for at least two years, so that they might start medical school in 1945, was turned down by the Secretaries of War and Navy. Dr. Rappleye expressed hope, however, that the idea would be favorably acted on later.

The number of medical students in the United States during the past decade has been pretty stable, hovering around the 23,000 mark, where it is today. For the last twenty years medical schools have graduated about 5,000 students annually. Now, with a yearly graduating class totaling about 7,300, and

deaths estimated at 3,500, there is a net annual increase of 3,800 doctors. In the period from 1942 to 1948, Dr. Rappleye emphasizes, this will mean more than 15,000 doctors net, after deaths.

General Hershey, adding his comments to those of Dr. Rappleye, charged recently that "there is undue concern over the future supply of doctors . . . After the war there will be an adequate number of physicians, for there are now in the medical schools a number of students greater than the number who ordinarily study medicine in peacetime . . . All of these will finish their interneships and be ready for practice by 1949 . . . We will then have not less than 193,000 doctors in the population as a whole."

Government policy in refusing to defer students is based, of course, on the assumption of an early peace. Despite the apparent optimism of Dr. Rappleye and some others, organized medicine feels that it must reckon with the possibility of a long war. If hostilities drag on and if the expected demobilization of service men does not take place as soon as anticipated, it says, a serious shortage of medical students can result; therefore, medicine is obliged to make preparations accordingly.

The AMA considers it no more than common sense for Selective Service to alter its stand and allow at least some boys to enter premedical work. Provision, it insists, should be made for the many youngsters who show promise in this field but are kept out of school by the rigid regulations governing deferment.

Even in wartime, the AMA maintains, an opportunity should be given the best qualified young men of the country to enter the profession of medicine. The number—about 6,000—is so small, it declares, that there can be no question of endangering the war effort. Six thousand men in an Army of twice that many million could not be a decisive factor in winning the war, it says, but 6,000 doctors *could* be a decisive factor in preparing for a lasting peace.

The AMA said last month that it "seriously questioned" some of the observations of General Hershey (see above). Presumably it also questioned those of Dr. Rappleye. Under the accelerated program, from 1942 to 1948, it stated, "there should be approximately 40,000 graduates. During the six prewar years, July 1, 1935 to June 30, 1941, there were 31,215 graduates. All other things being equal, these figures would indicate an increase in the physician population by 8,795 in 1948."

But, the AMA declared, "all other things will not be equal. This entire surplus physician population would be absorbed by a standing army of 1,757,000 men, at five medical officers per 1,000 men. Should the standing postwar navy require 5,000 physicians and the Veterans Administration 10,000, the physician population would actually be reduced by 15,000."

The AMA did not point out that the maintenance of a large standing army and navy would automatically reduce the civilian need for physicians to some degree. On the contrary, it declared, "Concern over the future supply of doctors is fully warranted. . ."

The opinions of medical men generally varied all over the lot (see Speaking Frankly, this issue).

—BENJAMIN FINE

AMA Loses Third Round in Fight Against Illinois Taxes

Court holds activities not solely scientific and educational

In Chicago, on June 19, 1944, Circuit Court Judge Michael Feinberg confronted the legal division of the American Medical Association with what looked like a prelude to the $350,000 question.

The court ordered dismissal of the AMA request for review of an Illinois Department of Labor finding that the association was not exempt from payment of unemployment taxes on behalf of a former employe. The court held that the former employe, who had been an AMA pressman in 1938, was entitled to receive unemployment benefits from the State of Illinois on the theory that the AMA was a liable employer during that year.

While attorneys for the association point out that the sum actually involved is only $152, the AMA has paid no unemployment insurance taxes to the State of Illinois since 1937. Unless its appeal of the latest ruling is successful, Illinois tax officials may attempt to collect back taxes since 1938 in behalf of the AMA's 653 Illinois employes. Should this happen, the sum involved would, a Chicago newspaper estimates, range from $350,000 to $500,000. AMA attorneys say it would be nowhere near $500,000.

Judge Feinberg readily agreed with the AMA's contention that it was a "scientific and educational organization," even adding his own opinion that it was a necessary American institution. But, he found, the AMA also took part in a number of activities that were not scientific nor educational. He cited, among other things, the AMA "theory and practice of expressing opposition to policies of other groups of doctors and certain lay groups, which indicates clearly an effort to influence public opinion."

Because of this, and such other matters as the U.S. Supreme Court decision that the AMA had acted in restraint of trade, the Illinois court concluded that "the AMA has not devoted itself exclusively to the activities and purposes for which it exists."

Judge Feinberg then ruled that the association, having destroyed its *exclusiveness* as a scientific or educational organization by these policies, could not claim exemption from payment of the state unemployment taxes in question.

As was to be expected, the AMA found itself unable to accept the adverse ruling and its embarrassing commentary on the association's function and purpose. The AMA's legal division announced early last month that it would appeal to the Illinois Supreme Court.

Difficulties with Illinois tax collectors are no new experience for the AMA. In 1938 and 1939, it paid unemployment insurance taxes to Illinois under protest. In 1939 the U.S. Treasury Department ruled that the AMA, as a scientific organization, was exempt from paying income taxes. The State of Illinois promptly returned the protested unemployment insurance taxes to the association.

The AMA press room employe concerned in the action had been laid off after working six months. He applied for state unemployment compensation. The State of Illinois, having refunded the taxes it had collected from the AMA, cut this employe's benefits accordingly.

The employe appealed. A state department of labor referee ruled in the AMA's favor, but the employe, supported by his union, appealed to a board of review which reversed the referee's findings. The AMA, in turn, took the case to the Chicago Circuit Court and lost it. Behind-the-scenes opinion is that the union is using the employe as a guinea pig—a reasonable assumption in view of the small amount of money at stake. Pending appeal, however, the AMA not only stands liable for this employe's taxes but has also been declared to be a pressure group.

The Chicago ruling will evoke no protest from at least one of the important AMA constituents. The Michigan State Medical Society, with an eye to the future, recently suggested that the national association change its organizational setup to permit economic and political activities, and pay whatever taxes might become necessary as a result.

—GORDON REPP

Two of a Kind

One of the doctors I work for is so busy that we maintain a waiting list of patients whom we call by telephone whenever an appointment is cancelled. The other day I phoned a man whose name had been on the list for a week. The woman who answered apologized at some length because Mr. So-and-So wouldn't be able to accept the appointment I offered. "You see," she finally explained, "we buried him this morning."

—ELLA BARNES

• After one of my patients, died, my wartime combination bookkeeper-nurse-receptionist sent the man's family an itemized bill for twelve house calls. A few days later, an outraged member of the family came to me with the bill, wanted to know how come? A quick look at the itemized dates showed me what had happened: Three of the calls were listed as having been made after the man died, two of them after the funeral.

—JAMES MATTHEWS, M.D.

U.S. Economy: 1944-45

There's a year of change ahead as we shift to a one-war strategy

Still booming along on its wartime course, industry nevertheless cocked a cautious ear toward Europe. There were indications that Germany might suddenly quit. If she did, American business would expect to enter the first of four economic cycles:

The first cycle would continue until the Pacific war ended. During its course, plant reconversion would be begun, might conceivably be half completed by the time the Japs were whipped. This period would be marked by growing unemployment.

The second cycle would be the real reconversion period, when the major part of the job would have to be accomplished, when unemployment might reach serious proportions.

Following this would come a boom era, born of the demand for durable consumer goods which have not been obtainable in wartime.

Finally, when this demand had been satisfied, the business cycle would swing into a period of more normal peacetime activity.

If military events followed the expected pattern, it was possible to foresee in a broad way how our national economy would be affected in each of the four periods. But if the war in the Pacific should end simultaneously with the German surrender, the hoped-for gradual transition to a peacetime economy would be seriously upset. Such a possibility, however, seemed wholly unlikely.

Chief threat to stability during the first period appeared to be that of inflation. If price controls should be relaxed while savings were still large and goods still scarce, prices might skyrocket.

Government demands for relief and rehabilitation are expected to ease the unemployment problem somewhat during the reconversion period. Nevertheless, certain communities are bound to be hit hard during this interim. Not only will many war workers be without jobs, but the demobilization process will have begun in earnest. The country as a whole, however, is expected to withstand the shock without dire consequences.

Guesses at how long the reconversion period will last range all the way from a few months to a year or more, its duration being largely dependent upon quick Government action in settling war contracts and in giving civilian industry the go-ahead. The general impression is that most plants can be producing civilian goods fairly soon after the last gun has been fired in the Pacific.

First steps have already been taken, of course, to get a limited number of plants going on peacetime production. A long list of products—ranging alphabetically from ash cans to wash tubs—have been given priority ratings by the War Production Board. But not until Germany is beaten can most manufacturers of these articles do more than place their orders for materials and tools.

Some industries have no reconversion problem. Timber producers, lumber and paper mills, textile manufacturers, and coal miners, for example, should all be able to expand productively as soon as more workers become available. As these increase their output, things will begin to brighten for many affiliated businesses—*e.g.*, printing, furniture manufacturing, box making, etc.

Topping the demand for durable goods in the boom period will be automobiles, refrigerators, radios, vacuum cleaners, sewing machines, washing machines, and the like. New housing, industrial expansion, and public works of a local nature are also expected to call for large quantities of material and great numbers of workers. Yet the first boom year will probably fall far short of wartime 1944; the national income this year should exceed $150 billion, whereas the most optimistic guesses for the first year of peacetime prosperity do not exceed $140 billion, $120 billion being a more likely figure.

How long the boom will continue is wide open to speculation. Two years, at least, the more conservative believe—while the dreamers are ready to predict a whole decade of prosperity.

Most businessmen hope for four or five years of steady demand before the inevitable slump sets in. It will take that long, they figure, to supply world needs, foreign as well as domestic. On the surface, their guess appears to be sound—especially when one considers that seven million wartime marriages have augmented an already tremendous potential market, that more than 600 different durable-goods items have not been manufactured since shortly after Pearl Harbor, and that savings after the war will be at an all-time high.

All told, the boom-time demand for consumer goods, both durable and non-durable, should exceed $100 billion a year, according to Harvard economist Sumner H. Slichter. Never in peactime history has the U.S. known a demand that great, he points out.

With such a considerable era of business activity ahead, it seems silly to attempt to gauge the more distant future at this time. Suffice it to say that few of the business prophets foresee any signs of a major depression in the early postwar years.

It was not the boom period, however—nor even the reconversion period—that most concerned investors last month. Their chief topic of discussion was the extent to which postwar profits would be sawed off by continued high Federal taxes. For with the excess-profits tax rescinded, the government will have to make heavy demands on corporations and individuals alike in order to try to balance its budget. Some relief is expected if national income exceeds $120 billion annually; if it falls below that figure, no appreciable cut in taxes is probable.

Tax discussion has been further warmed up by announcement of the

new plan of Beardsley (Pay-As-You-Go) Ruml and H. Christian Sonne. The proposal: elimination of all corporation taxes (with the exception of a 5 per cent franchise levy) in favor of higher direct taxes on individual incomes. The theory: Wages could be increased, the cost of living reduced, and double taxation avoided by the proposed procedure. If anyone other than Mr. Ruml had suggested the plan, it would probably have been laughed off immediately, and may even be yet. He himself admits that his main aim in proposing it was to stimulate thinking on the problem. In that, he has succeeded admirably.

Widely held was the belief that European rehabilitation would soon get into high gear—probably even before the year's end. Many thought that the wartime production peak had already been passed, though September or October was expected to be the month when national income would hit its highest level. The balance of 1944, it appeared, would see no startling change in the over-all economy. Tires might become more plentiful, food rationing a little tighter; the supply of other goods would remain pretty much as it had been throughout the summer.

Next year was another story. With Germany out of the way, cutbacks in war production would mean steadily mounting unemployment. Demobilization might return as many as 3,000,000 men to civilian life. Strikes would probably be more numerous. Rationing and price controls would be eased. Competition in some lines would become stronger. Prices would tend to rise. Public works projects would be started as the year wore on. Social security reserves and savings would halt their rapid upward trend, might even show a noticeable drop. If Japan remained unbeaten by January 1946, about half of U.S. production would still be devoted to Army-Navy needs.

Roughly, this was the outlook for the next twelve to sixteen months—for most of the analysts still believed that the war against the Japs would continue well into 1945, possibly for two or three years beyond that. Until better guesses are available, one must accept the belief that 1945 will be a year of great transition—a year when business indices must be watched as closely as a patient in an oxygen tent. —NORMAN NASH

No Hive

Sometimes a casual remark, even when made with the best of intentions, is better left unsaid—as I learned during my internship. Entering an elevator, I encountered a young couple accompanied by one of our chief nurses. The man was carrying a wooden box about the shape and size of a beehive. Smilingly I asked, "What have you there—a hive of bees?" A painful silence told me I had spoken out of turn. "No, Doctor," the nurse finally said, "This man's baby is in the morgue. He has come to get the body."

—WILLIAM MACDONALD, M.D.

The Wrong (and Right) Approach In Collection Letters

Beware of stock phrases! Many are psychological duds

A debtor should pay his bills because he owes them. And for no other reason.

Elementary as this seems, it is often forgotten. Too many collection letters stress reasons for paying that are ingenious but invalid.

The transparent and threadbare bits of hypocrisy with which many such letters are studded accounts at once for their ineffectuality. Consider, for instance, the theme:

"I have my own bills to meet."

This approach is intended to arouse the spirit of fairness. Yet actually it emphasizes no reason at all for paying. The patient isn't the slightest bit interested in the physician's financial worries. What's more, he probably thinks he needs money more than the doctor does, anyway. Meanwhile, the creditor has lost dignity. He has admitted economic weakness. Which may suggest professional weakness also.

Equally unconvincing is the theme:

"No doubt you have overlooked this matter."

This is soft-soap, and recognizable as such. People who take their obligations seriously (and thank heaven they are in the majority!) do not overlook their bills. On the contrary, they have them very much in mind. This phoney approach may well serve, therefore, as a first-rate irritant.

A sincere expression of confidence produces an infinitely better reaction: "I'm sure you have this matter in mind and will want to send a check at the earliest possible opportunity" lets the debtor out gracefully and, best of all, will probably elicit a check.

Next collection-killer centers on the theme:

"I hesitate to bring this matter to your attention" or *"I don't like to annoy you with statements."*

This one is poison. You're licked the minute you take the defensive. The apologetic appeal arouses little more than contempt.

Consider, instead, the straightforward approach: "I have not hesitated to bring this to your attention because I know that a man who regards his obligations seriously has no objection to a frank discussion of them." This forthright statement commands respect and hits the jackpot.

A salesman who opened his talk by saying, "You don't want to buy any brushes, do you?" would make few sales. Yet often we find collection letters that ask plaintively: *"Can't you send your check today?"*

The immediate impulse is to answer, "NO!"

Another poor approach is found in the letter which says:

"I hope you'll favor me with an early remittance." This ignores the fundamental concept of credit already mentioned: that a debtor should pay his bills because he owes them, and not as a favor to anyone.

A collection letter can be depended upon to arouse antagonism when any variations of the following are used:

"You have ignored previous notices . . ."

"Ignore" is a pretty strong word. What's more, the phrase is an accusation of boorishness. Result: injured pride and no pay.

"You haven't given me the courtesy of a reply."

Hardly courteous itself.

"You have failed to answer . . ."

Nobody likes to be told he has failed in anything, no matter how trivial.

"Why hasn't this account been paid?"

The abrupt question puts the debtor on the defensive and is likely to make him good and mad.

Here are three collection don'ts:

Don't present more than one argument in the same letter. A single point, well stated, carries the most conviction. Several points confuse the issue.

Don't offer too many alternatives to immediate payment. When a letter suggests payment, part payment, a letter of explanation, a person-to-person discussion, and a handful of other choices, it loses force. The debtor recognizes its weakness and does nothing.

Don't close the letter without a sentence suggesting definite action. "Please send your check today" leaves no excuse for temporizing.

An uncompromising ultimatum is better not issued. Avoid the temptation to say, *"If this account is not paid by October 1 it will be turned over to a collection agency."*

Many an otherwise peaceful person will balk like a mule when confronted by a dictum of this sort. If, with it, however, he is offered some means of saving face, he will probably jump at the opportunity. Appealing to his self-interest, you might say, "No doubt you will want to save yourself the expense and embarrassment which arise when it becomes necessary, in the case of an account as old as this, to turn it over to an agency for collection."

To a degree which collection-letter writers seldom completely realize, human behavior is motivated by pride and the desire to maintain self-esteem. Get pride working for you, and you can influence that behavior in a big way. Wound it, and Heaven help you.—H. M. SOMMERS

No Room for Error

The prospect of losing a kidney had the woman in a dither. Yet not until the surgeon prepared to operate did he learn the real cause of her alarm. Lettered boldly in mercurochrome on the left side of her abdomen were the words, "Remove THIS kidney"; and on the right side, "Not this one—the OTHER one."

—BERTA WIMURR, R.N.

Medical Smorgasbord

Sweden's complicated medical plan seems adequate—for Sweden

In several states where movements are afoot to improve medical care, talk is heard about the Swedish pattern of medical service and the possibility of adapting it to American needs.

Californians, for instance, already noted for their experiments in the distribution of medical care, often cite the Swedish plan as an example for emulation, pointing out their state's similarity to Sweden in size, population, and industries.

It seems likely that much of this admiration arises from incomplete understanding of the Swedish people and their medical system.

Sweden has a population of only about 6,500,000. One half its people live in rural regions and work as farmers, lumberjacks, fishermen, and small craftsmen. There are only three cities with more than 100,000 population.

The Swedish standard of health is high, life expectancy being 60 years. Sweden has practically no smallpox or typhus, little diphtheria, not much tuberculosis, and a low incidence of venereal disease.

The Swedish health insurance system is purely voluntary, and has been in effect since 1891. Proposals to make it compulsory were rejected in 1930, but a new plan now under consideration by the Riksdag would extend health-society coverage to the entire nation on a compulsory basis, beginning in January 1947. At present, 2,000,000 Swedes—less than a third of the population—are insured.

The system is operated through registered sickness benefit societies partly subsidized by the government. Membership in these is open to all, male or female, between the ages of 15 and 40 (in some cases 50) who are in good health and free from any disability requiring prolonged medical care. Workers are insured for both hospital and medical treatment but the latter benefit is available only to those who taxable income is under $2,000 a year.

Premiums range from 20 cents a month (which secures a sickness benefit of 20 cents a day) up to $1.45 a month (which secures the maximum benefit of $1.20 a day).

State subsidies to the societies vary with the number of society members, but average $2.55 a year per member if the insurance covers both sickness benefit and medical attendance. Local authorities also make voluntary contributions to the societies, to aid in building reserves against the cost of member-illnesses.

While the government subsidizes all medical services, no service is completely free. In every case the patient must pay part of the cost. The fundamental philosophy is that

each man should help himself to the utmost. Thus insured patients pay about a third of their hospital costs; the societies and the government pay the rest. Clinic patients pay about 50 cents per visit. Only if a patient is utterly indigent does the government pay his entire bill.

The government directs medical service through a national Medical Board, which is part of the Ministry of the Interior. This board directly controls pharmaceutical and bacteriological laboratories. It inspects hospitals and medical services. And it prepares health plans for the nation's twenty-five counties and the 2,000 communes that look after local health and welfare. The national board is free from political interference.

The number of Swedish medical practitioners has doubled in the past thirty years. Today there are about 3,000 doctors, or one for every 2,000 people.

Most of Sweden's doctors are employes of the government in one way or another. A great many of them, however, practice privately as well, although only about one fourth of them confine themselves exclusively to private practice. Most private practitioners are located in the larger cities.

The fees Swedish doctors may charge are regulated by the state and are moderate. First-consultation fee is $1.75, subsequent consultations are from 75 cents to $1.25. For a major operation in a state-subsidized hospital the patient may have to pay the surgeon from $25 to $50.

Swedish doctors other than private practitioners are classified as either hospital, district, or provincial physicians. The head of a city hospital department—the chief surgeon, for example—receives a salary of about $3,500 per year, and may earn an equal sum from his private practice. His assistant, whose salary is approximately $1,750 a year, may engage in private practice only within the hospital. All others are on salary, with their living expenses paid by the state.

House physicians get $1,400 per year, and assistant residents $750. They cannot undertake private practice. Their pay is also supplemented by free keep and old-age pensions. These rates are typical in city hospitals.

In the rural areas, medical service is supplied by district and provincial medical officers. They also receive base pay from the state, and most of them earn an equal sum in private-practice fees, bringing their average yearly income to about $4,000.

If transportation difficulties are not too great, a rural medical officer may bring patients to one of the state-subsidized cottage-hospitals, which contain about forty beds each, or to a central hospital.

A district medical officer may find himself with as many as 4,000 people to look after. Consequently, many Swedes do not get all the attention they need or want. They complain frequently to the government. The medical officer replies, truthfully, that he is doing his best.

Practically all the hospitals, sanitoria, and clinics in Sweden belong to the counties. All are utilitarian and unornamented, but are roomy, well-equipped, and clean. Institutions provide three beds for each 1,000 population. Treatment is free for those suffering from infectious diseases.

All patients, including those insured, must pay part of the cost of hospitalization, which ranges from 20 cents daily in public wards to $1 per day in private rooms. Swedish fire departments provide free ambulance service.

About 31 per cent of the total cost of hospital administration is met with patient's payments; the balance comes from the government. Medical work in most hospitals is done by a senior medical staff, which lives out and does private practice, and by assistants who live in.

The services of midwives are widely utilized by Swedish mothers, of whom more than 90 per cent get a government maternity allowance. There are six midwives for every 100 women of child-bearing age, and they use institutional facilities for about one-third of their confinements.

Midwives get two years of basic training, and are competent. They charge no fees, but the government pays each midwife about $400 per year, also providing professional equipment and living quarters. For each delivery above 50, the midwife gets an extra $2.50 from the government.

Summing up, Sweden's medical services appear to be good in the cities, fairly satisfactory in small communities, and unsatisfactory in rural or thinly settled areas. The Swedish medical system appears, on the whole, to be adequate—for Sweden. —NORMAN T. WILLIAMS

"Shouldn't you send your bill to the Government? It happened while I was cutting the ends off a tin can."

Closed Hospital 'Abuses' Must Be Corrected, Truman Says

Vice Presidential candidate takes unequivocal position

America is headed straight for state medical control unless medicine finds a way to eliminate the abuses of the closed hospital system, says Senator Harry S. Truman of Missouri, Democratic Vice Presidential nominee.

This uncompromising opinion is contained in a signed telegram to Dr. James W. Graham, Kansas City surgeon, acknowledging a letter that pulled no punches in its strong criticism of medical and executive staffs of U.S. hospitals. Many of these institutions, Dr. Graham told the Senator, are operated solely for the convenience and financial gain of staff doctors, at the expense of patients.

Queried by MEDICAL ECONOMICS on the background of his correspondence with Senator Truman, Dr. Graham said that he had written the letter in order to explain his own views before seeking the Senator's views on socialized medicine.

"An earlier letter from my good friend, Senator Truman," said Dr. Graham, "was so much to the point and showed that he had such accurate knowledge of the medical profession and of the necessity of medical care for the public, that I decided to write him my actual experience and knowledge relative to some of the harmful things in the profession that should be corrected."

Dr. Graham's letter and Senator Truman's reply are published here in condensed form through the cooperation of the Jackson County (Kan.) Medical Society:

Honorable Harry S. Truman,
Senate Office Bldg.,
Washington, D.C.
Dear Harry:

Following is the real situation in at least 90 per cent of all the hospitals in the United States:

Almost all hospitals have been built by public subscription; therefore, when operating expenses exceed income, the deficit is met in the same way. According to the ethics of hospitals and the medical profession, hospitals should accept all patients who need surgery or medicine, regardless of who their doctor may be, as long as he is in good standing within the profession. But too often the patient, regardless of his physical condition, becomes a minor consideration.

Many hospitals are for the sole use, convenience, and financial gain of the doctors on the staff, especially the members of the executive staff who in nine cases out of ten have never contributed a penny to the building or its maintenance.

As a result of this "understand-

ing" among the staff, only the patients of the staff, with but few exceptions, are admitted to the hospital.

The alleged purpose of any hospital staff is to conduct meetings in which scientific papers are read and discussed; to entertain suggestions and recommendations for the benefit and improvement of the hospital. The ultimate objective should be better care and treatment. However, facts reveal that the real purpose of the staff is to advance the selfish ambitions of those doctors who, in plain words, are politically right with the staff, principally the executive and active staff.

The staff in such a hospital dictates which doctors' patients will be admitted. This results in the staffs' choosing the doctors who will be admitted as members of the staff.

If the physician seeking membership on the staff is regarded as a competitor to those already on the staff, his application is immediately refused, regardless of his qualifications. His patients are denied admission to that hospital unless they discharge their own doctor and obtain the services of some member of the staff.

This is not right. State and national laws should be the determining factor—not a group of men who have no legal or moral right to pass on doctors' qualifications.

To give you an idea of the shameful way in which the public is treated by many hospitals, I cite a few cases:

¶ A patient who had been Insurance Commissioner of Missouri and brother of one of the governors had a cerebral hemorrhage. He was taken in a dangerous condition to the hospital but was kept waiting in a car for over an hour while the doctors were deciding which member of the staff would take charge of him. This man has never regained his speech and has been an invalid since.

¶ A doctor called a hospital to reserve a bed for a patient with acute appendicitis. Immediately he was asked who was to do the surgery. When he replied that he would, the room clerk was, "Sorry, every bed is taken." The fact of the matter is, rooms 501, 503, 508 and 509 were vacant then and had been for days. Moreover, 511 would be vacant the next morning. This was on one floor only. So far as this hospital was concerned the patient could die.

Here is another angle of the power accorded the staff of a hospital:

No doctor may practice anything except the specialty under which he is listed on the staff records. This ruling may be excellent for a wealthy person; but for a poor person or one of moderate income, medical care becomes prohibitive or financially wrecks the patient. To illustrate:

¶ A patient entered one of the leading hospitals of our city. During the year she was referred to that hospital three times. The third time she was hospitalized for eighteen weeks. Six or more specialists called on the case; each charged a specialist's fee. These fees ranged from $50 to $178—to say nothing of the hospital bill of almost $1,000. Upon discharge, the patient was still a physical wreck. The family doctor was recalled to take care of the case. The husband is a small-salary man, around whose neck there will be a yoke for years to come.

No corporation in the world controls prices more than the staffs and hospital organizations of the United

States. The strange part of it is that there are, except in a few states, no laws, either state or Federal, that will prevent the hospitals or the staffs of the hospitals from continuing these barbaric practices.

Actual sicknesses and deaths can be attributed to the system, and great injustice is done to the many legally qualified doctors affected. This condition, if allowed to continue, will do more harm to a public that needs medical and surgical care than will socialized medicine.

While it is a fact that socialized medicine has never in any country provided adequate treatment for all the people it is intended to benefit, and while the writer does not approve of socialized medicine, still there is one thing that may be said for the Wagner-Murray bill now pending: It at least has some provisions that would govern the actions of hospitals and hospital staffs.

Let us have some state and Federal laws that will allow any physician licensed in a state to have his patients admitted to any hospital in the state. Let the care and treatment of any person in need of medical care be the first consideration.

Jim.

DR. JAS. W. GRAHAM,
ARGYLE BLDG., KSC.

UNLESS THESE ABUSES ARE ELIMINATED WE ARE HEADED STRAIGHT FOR STATE MEDICAL CONTROL. WILL WRITE YOU MORE FULLY WHEN I RETURN TO WASHINGTON.

HARRY S. TRUMAN

At press time, Senator Truman's letter, expanding on his views, was not yet available for publication.

—LAWRENCE A. ENRIGHT

"DOCTOR!! — PLEASE DON'T BE VULGAR!!"

DISSECT THAT WORD!

If your Girl Friday is often stumped by medical terms, have her read this

Does your secretary transcribe *elephant* for *allophen*, *osculation* for *auscultation*, *flea bites* for *phlebitis*?

Perhaps not. But it's ten to one that unless she's an R.N. her grasp of medical terminology leaves something to be desired. The advantage of improving it, in terms of time saved (both hers and yours), is too obvious for comment.

How to do it? Here are some hints to her that you may pass along:

Perhaps the first step in building a medical vocabulary is to recognize that most words are constructed according to a pattern. They have a root, which shows what they relate to, completed with a prefix or suffix (or both) which modifies the root.

Medicine is forever striving for exact description of the human body and its diseases. Medical terminology aims to be precise. Thus, *menopause* means *monthly* (meno-) *cessation* (-pause). *Amenorrhea* means *no* (a-) *monthly* (-meno-) *flow* (-rrhea). *Dysmenorrhea* means *difficult* (dys-) *monthly flow*.

In the box below are other examples of dissected words. They show you how to break a medical term down into its components and quickly comprehend its meaning. On the opposite page are lists (far from complete!) of roots, suffixes, and prefixes. Memorize them and their definitions, seek out unfamiliar terms in the medical dictionary, and in no time at all you'll be able by dissection, to understand practically any medical word.—PARKER L. MAYS

MEDICAL WORD BUILDING

Modifier	Root	Modifier	Word	Meaning
hyper *excessive*	emia *blood*	—	hyperemia	excessive blood
—	osteo *bone*	oma *cancer*	osteoma	bone cancer
endo *within*	cardia *heart*	itis *inflammation*	endocarditis	inflammation within the heart

SOME COMMON COMPONENTS OF MEDICAL WORDS

ROOTS

head	caput, cranium, occiput	bronchial tubes	bronchi
neck	cervix	heart	cardia
ear	auris	stomach	gastrium
eye	ophthalmus	liver	hepar
nose	nasus	kidney	nephros, ren
throat	pharynx, larynx, fauces	womb	uterus
		skin	cutis
mouth	os	joint	arthron
teeth	dentes	spinal cord	myelon
tongue	glossa, lingua		

PREFIXES

a–	lacking, not	myelo	marrow, spinal cord
ab–	from	myo–	muscle
ad–	to	nephro–	kidney
adeno–	gland	neuro–	nerves
ante–	before	ortho–	normal, straight
arthro–	joint	oto–	ear
auto–	self	para–	apart from, next to
dis–	negative	patho–	diseased
dys–	difficult, painful	peri–	around
ecto–	on the outside	phlebo–	vein
endo–	within	pneumo–	lungs
entero–	intestine	post–	after, following
gastro–	stomach	pre–	before, preceding
hyper–	over, excessive	procto–	anus
hypo–	under, decreased	pyo–	pus
hystero–	uterus or hysteria	pyro–	fever
intra–	within	rhino–	nose
meno–	menstruation	sarco–	flesh
metro–	womb	tropho–	nutrition
micro–	small	utero–	uterus

SUFFIXES

–algia	pain	–oma	tumor
–dynia	pain	–osis	condition
–ectomy	excision	–ostomy	opening
–esthesia	sensation	–otomy	incision
–genous	kind	–pathy	disease, disorder
–itis	inflammation	–rrhea	a flow
–logy, ology	science	–scope	see, examine

Blue Cross 'Comprehensive' Hits Snag in Iowa

Radiologists' objections are said to reflect nation-wide opposition

Last month a number of radiologists were concluding that the Blue Cross's so-called "comprehensive" contract would eventually lead to a hot court fight. Nominal opponents, they thought, would be a radiologist vs. a state hospital plan. Backers and strategists would be the AMA in one corner and the AHA in the other.

The issue: Is the Blue Cross engaging in the corporate practice of medicine when it pays a hospital directly for the services of radiologists, pathologists, etc.?

Some observers believed the flare-up would come in the Midwest, where, they said, there were indications that the Iowa X-ray Club would seek a court injunction barring the inclusion of radiology, pathology, anesthesiology, and cardiology in the Blue Cross contract.

Events leading up to a showdown date back to April 1943, when Iowa's Hospital Service, Inc. (Blue Cross) asked the state medical society to give its blessing to a proposal to insure against the costs of the four services. According to Dr. Robert L. Parker, the society's secretary, its executive council "voted to have the Blue Cross pay the hospital as agent for the physician, rather than the physician directly."

But the Iowa X-ray Club had ideas of its own. An official version says its objections were limited merely to the phraseology of the contract, but insiders have insisted that the membership opposed the principle of direct payment to hospitals, whatever ostensible form it took. They point out that to the salaried radiologist the word "agent" was academic, and that the contract arrangement tended to hamper the old struggle of the American College of Radiology to end salaried hospital practice by its members.

Thus the Blue Cross was put on the spot. If it decided to pay laboratory specialists directly, there would be a howl from hospitals with salaried staffs. If it stuck to its contract it faced the possibility of court action by the radiologists. And the Blue Cross—nationally and locally—has carefully avoided any legal battle involving the charge that it has engaged in corporate medicine.

Such was the Iowa picture as drawn by several radiologists. They said the dispute had been a hot one. On the other hand, representatives of the medical society and of radiology declined to characterize it as even a tempest in a teapot. One of the latter, who sat on a committee that met with directors of the Blue

Cross, told MEDICAL ECONOMICS:

"It is true that the Blue Cross Plan included payment of X-ray, clinical laboratory services, and anesthesia without making a distinction between the hospital's services and professional services." But, he added, "We did not encounter any trouble with the directors of the Blue Cross in having them remove this from the hospital services. They have agreed to pay for such medical service directly to the doctor or his agent in the future. It was not necessary to institute suit or even to threaten suit."

Dr. Robert L. Parker, secretary of the Iowa State Medical Society, late in June asserted that "The matter . . . has been settled in accord with the wishes of the Iowa State Medical Society and the radiologists. At its worst it was only a matter of phrasing, and that has now been adjusted satisfactorily." But not finally, it appeared as this issue went to press. Dr. Parker revealed then that the Iowa X-ray Club was still meeting with the Blue Cross directors in an effort to work out a solution.

While the other clinical specialists have a large stake in any such dispute, the radiologists are taking the lead. For one thing, they have a vigorous organization, the American College of Radiology. For another, their services to the patient are primary. Conversely, pathologists perform many duties (*e.g.*, autopsy, biopsy) for which they cannot directly bill patients.

The comprehensive contract, approved by the American Hospital Association, has produced a number of thorns. Organized medicine, of course, has for some time regarded it as a hospital salient in the field of medical practice. But the Blue Cross insists that the comprehensive contract does not affect the patient-physician relationship, that it was designed solely for the benefit of the subscriber, and that the latter regards clinical laboratory work, radiology, etc., as proper hospital functions. Radiologists retort that it is the contract *per se* which leads the subscriber to believe that, rather than to realize that such laboratory work is the function of a physician in a hospital.

Medicine also contends that as the plan becomes better known, subscribers may demand unnecessary services—on the theory that everything is free—and thus place an unnecessary strain on the specialists. This, it is felt, would result in a lower quality of medical service.

—PETER COLLINS

Slightly-Pregnant Department

A young, unmarried Spanish girl complained to me of a missed menstrual period. She denied any possibility of pregnancy, but the A-Z test was positive. After giving her this information, I heard no more from her until several weeks later when she telephoned and said, "I've found some one to do an abortion, but it costs $75 and all I have is $40. Will you lend me $35?"

—ROBERT MASON, M.D.

A Runaround for the G.P.

The AMA, he feels, has been giving him one for too long

When 376 physicians attended the Sessions for the General Practitioner at the 1944 AMA convention in Chicago, many a G.P. concluded that it was high time he and others like him were accorded official status by the national association. The AMA, however, has declined so far to authorize a general practice section. This despite the fact that of the seventeen sections which met at the AMA convention, the one on Miscellaneous Topics* ranked fourth in attendance.

Some general practitioners feel that they have been discriminated against in still other ways. At the convention, for example, their sessions were the only ones held in the Morrison Hotel. Almost all the others took place at the Stevens or the Palmer House. The inconvenience was not great, yet a number object in principle to having been, as they put it, "pushed around."

Dr. Wingate M. Johnson of Winston-Salem, N.C., secretary of the sessions, believes that the AMA will eventually have to establish a section for general practitioners. He points out that attendance has been high ever since the sessions first met in 1942, after the House of Delegates had authorized a tentative program. Another index of appeal, he says, is the fact that at the 1944 convention the Reference Committee on Sections and Section Work strongly recommended the establishment of a full program of scientific papers for the Section on Miscellaneous Topics.

Not all speakers at the last meeting of the section were general practitioners. Dr. Johnson says the tendency, though, is for G.P.'s to dominate the program.

In 1941 an AMA reference committee turned down a resolution to provide a full-fledged section for general practitioners, arguing that they should be able to find enough to interest them in the already established sections, and that there were too many sections anyway. Other medical organizations have been more receptive. The North Carolina Medical Society established a section for G.P.'s as early as 1938. The Southern Medical Association formed one in 1942. And these are not all.

A resolution advocating official status for general practitioners was introduced at this year's AMA convention. But it got nowhere.

Delegates also listened to a resolution calling for the creation of a board of general practice, similar to

*At present, the Section on Miscellaneous Topics embraces only the Sessions for the General Practitioner.

the specialty boards. The resolution pointed out that "standards and requirements for membership in the general practice sessions and norms for hospital staff admission should be prescribed and established." It recommended that the job be done by a board consisting of seven general practitioner-members of the AMA.

The Reference Committee on Medical Education refused to pass on the resolution "because of lack of jurisdiction," and suggested it be sent to the Council on Medical Education and Hospitals. According to Dr. Victor Johnson, secretary, the council will act when it meets this November. He says, however, that the council will probably make nothing more than a general recommendation, to the effect that "It is possible such a board would fill a real need."

This recommendation will then be referred to the Advisory Board for Medical Specialties, which will not be able to consider it until February at the earliest. Assuming that the board approves, and a definite program is proposed, it will then have to meet standards set by the Council on Medical Education and Hospitals. All in all, Dr. Johnson considers it unlikely that a board of general practice, even if authorized, can get into operation within the next twelve months.—C. A. LIBBEY

Insurance Questions & Answers

Term vs. straight life; "earned premiums"; other problems

Q. I served in World War I, and have since continued to carry Government war risk life insurance ($10,000), renewable every five years on a term basis at an increased premium. I am now sixty, It is my right to renew for two more five-year terms (at $30.60 per thousand for the first term, $46.78 for the second); or I may convert to straight life (at $58.36). Should I renew or convert?

A. Converting offers one definite advantage: At the age of seventy, you will still be insured—whereas, under term renewal, your insurance will cease at that age. If you are then alive, still need the insurance, and can pay the premiums, the added cost of conversion will have been well justified. At sixty, the average life expectancy is fifteen years. Actuarially speaking, there is a fair chance that you may die before you are seventy—in which case renewal of your term policy would obviously be the less expensive choice. Term insurance costs less because the risk is limited to a definite time—five years in your case. When the term is up, the insurance is no longer in force. Since you cannot renew the term contract after seventy, it rather looks as though you will have to decide for yourself what your life expectancy is and whether after seventy, if you live, insurance will be a necessity.

Q. My wife is the beneficiary of my life insurance, which is payable at my death in a lump sum. If she invests the money, will she be required to pay a Federal income tax on the return she receives?

A. Yes—subject, of course, to allowable exemptions. On the other hand, if your insurance proceeds are made payable as income rather than in a lump sum, that income, under a ruling of the Bureau of Internal Revenue, will be tax free. The principal sum of the insurance, however, will be subject to inheritance tax, if the estate, after allowable deductions, exceeds $60,000.

Q. My brother and I practice together, and often use each other's cars. If I had an accident while driving his, would my automobile insurance cover the liability?

A. Yes. The standard policy is-

► If you are confronted with an insurance problem of broad interest to other physicians, submit it to J. Edward Deming in care of this magazine. If suitable for publication, the question and his reply will appear in these columns.

sued by most companies was liberalized not long ago to cover this situation. The insurance applies whether the policyholder is driving his own car or the pleasure car of another.

Q. Fourteen months ago I purchased personal accident insurance. This year, when the renewal premium notice came, I decided not to renew. I did not bother to notify the company. Now, after two months, it has sent me a cancellation notice (for failure to pay the premium) and a bill for what it calls an "earned premium" for the past two months. Am I obligated to pay it?

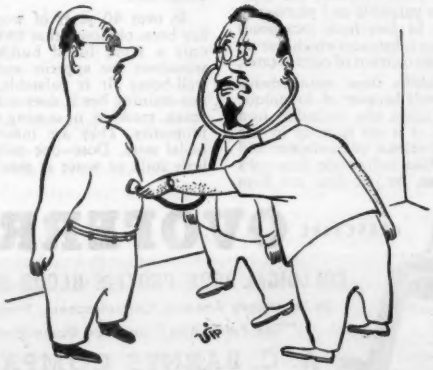
A. No. You signed only a one-year contract. Although the company indicated its willingness to renew by sending you the renewal notice, you had no contractual obligation to notify it of your adverse decision. The company would have been liable for any claim you might have made during the past two months (unless the contract specifically stated otherwise); but actually it would not have settled such a claim until you had paid the renewal premium. Legally, you are not liable for the "earned premium."

Q. If my wife and I were to die in a common accident, who would receive the benefits of my life insurance policies, in which she is named as the sole beneficiary? We have no children.

A. If it could be established that your death preceded that of your wife—even by a few minutes—her estate could claim the benefits. In other words, her relatives would get the proceeds—to the complete exclusion of your own family. But if it could be proved that she predeceased you, the situation would be reversed. You can, if you wish, name a contingent beneficiary in each of your policies—one or more specific persons who would receive the benefits if your wife predeceases you or dies before she actually becomes the beneficiary.

—J. EDWARD DEMING

Virgil Partch
in Collier's



"By the way, Gormely, this is my consultant, Dr. Steger."

American Doctors Predict New Federal Encroachment

Survey also discloses doubts about quality of profession's leadership

More—much more—Government intervention: That's what a majority of doctors predict for medicine in the next few years. Only a mere handful (2 per cent) anticipate decreased Federal control. These and other facts have been brought out in the first of a series of surveys by MEDICAL ECONOMICS, based on a coast-to-coast cross-section of U.S. physicians in civilian practice.

First question asked was: *"Do you predict more or less Government in medicine in the next few years?"* Respondents expressed the following opinions, in the percentages indicated:

Much more	53.0
Slightly more	29.0
Slightly less	1.0
Much less	1.0
Neither more nor less	5.0
Depends on election	10.5
No opinion	.5

Typical comments were as follows:

"A try at Government control is inevitable."

"Keep your eye on the English situation; we always follow by some years what they do, whether we like it or not."

"God save medicine if the unions continue to dictate Government!"

"Ex-servicemen's care will be greatly increased by establishment of new facilities. This will be an entering wedge."

"Much more Government control if Roosevelt is elected; much less if Dewey wins."

Second question: *"Do you favor more or less Government in medicine?"* The replies:

Much more	5.0
Slightly more	9.5
Slightly less	13.5
Much less	57.5
Neither more nor less	13.5
No opinion	1.0

"State medicine would be a good thing if confined to those earning less than $2,000 a year," one practitioner declared.

Said others:

"Once the present 'Government' gets its little toe in the door leading to Russianism, the two feet will follow. And then? Goodbye to private medicine! M.D.'s will be but robots, controlled from the White House."

"Social medicine might succeed with physicians as leaders, but as a political football it would be catastrophic."

"I think every state should take care of its own affairs according to local conditions."

"My idea of Government assistance would be a fund for the down-and-out, to be administered in each

Little David

The moral is simple—a small but well-aimed effort frequently does the trick.

In constipation, too, a well-directed therapeutic effort is more than a match for brute force. 'Agarol'* Emulsion aims at "effortless" correction of constipation by providing soft bulk and lubrication, by holding moisture in the stool and by mildly stimulating peristalsis. 'Agarol' Emulsion does this deftly, providing the minimum stimulus needed for evacuation. And with 'Agarol' Emulsion there need be no griping, no leakage. . . . William R. Warner & Co., Inc., 113 West 18th Street, New York 11, N. Y. *Trademark Reg. U. S. Pat. Off.

'Agarol'

EMULSION OF MINERAL OIL WITH PHENOLPHTHALEIN AND AN AGAR-GEL

county by, say, a probate judge, so that any doctor could collect a bill, discounted perhaps 50 per cent, when it became impossible for the patient to pay."

Third question: *"What do you think of the quality of leadership medicine is getting from its leaders generally?"* The replies:

Good	49.5
Fairly good	2.5
Good in some ways	2.5
Fair	2.0
Poor	42.0
No opinion	1.5

Virtually all the comments made come from complainants. Thus:

"Under AMA leadership we cannot hope to prevent Government control. If the Association of American Physicians and Surgeons can enlist 75 per cent of the doctors of each community, then we may keep medicine as it should be."

"Medicine has poor leaders—sterile of constructive ideas and ostrich-like in attitude."

"There is absolutely no first-rate effort to enlighten the public against the fearful threat of socialized medicine."

"Leadership is generally narrow, selfish, and reactionary—even as medicine receives new recognition every day for its scientific strides."

Fourth question: *"Some critics accuse the medical profession of having offered no satisfactory alternative to the Wagner-Murray-Dingell program. Do you agree or disagree?"* The answers:

Agree	34.5
Disagree	60.5
Neither	2.0
No opinion	3.0

Following are sample comments:

"The California Physicians Service is doing an excellent job of offering an alternative to the Wagner program."

"I can't see any reason for medicine to offer an alternative. We've served the public satisfactorily for more than a century. Why consider the Wagner bill at all except to condemn it?"

"I suggest more voluntary medical and hospital insurance plans."

"There has been too much crying on each other's shoulder in the medical profession. There has been no *bona fide* effort to offer the public a workable substitute for the Wagner bill."

"I think specialists are the real cause of socialized medicine. Group clinics and overcharging are the great blunders."

On the fifth question, *"What do you think of the job being done by the National Physicians' Committee?"* there was wide divergence of opinion:

Approval		
Excellent	18.0	
Good	23.0	
Okay	4.0	45.0
Semi-approval		
Fair	7.0	
Good start, promising, etc.	8.5	15.5
Criticism		
Poor, weak, negative, etc.	10.0	
Other criticisms	8.0	18.0
Don't know much about it		11.0
No opinion		10.5

Those approving the committee's efforts had few comments to make. The remarks of the others ranged all the way from "Could be better" to "Too self-seeking" and "Dangerous." [*Continued on page* 77]

Doctor of Medicine...

HE WEARS the same uniform . . He shares the same risks as the man with the gun.

Right this very minute you might find him in a foxhole under fire at the side of a fallen doughboy . . .

Jumping with the paratroopers . . . riding with a bomber crew through enemy fighters and flak . . .

Or sweating it out in a dressing station in a steaming jungle . . .

Yes, the medical man in the service today is a fighting man through and through, except he fights without a gun.

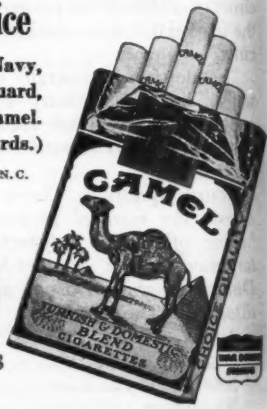
They call him "*Doc.*" But he's more than physician and surgeon: he's a trusted friend to every fighting man. And doctor that he is . . . doctor of medicine and morale . . . he well knows the comfort and cheer there is in a few moments' relaxation with a good cigarette . . . like Camel.

For Camel, with the fresh, full flavor of its incomparable blend of costlier tobaccos and its soothing mildness, is the favorite cigarette with men in *all* the services.*

First in the Service

***With men in the Army, Navy, Marine Corps, and Coast Guard, the favorite cigarette is Camel. (Based on actual sales records.)**

R. J. Reynolds Tob. Co., Winston-Salem, N. C.



Camels

COSTLIER TOBACCOS

...and Morale

Additional views:

"The committee seems to be less concerned with the distribution of medical care than with maintaining the *status quo*."

"Have always felt that the AMA should speak for us all. Do not see the need for a separate organization."

"In European countries, most of the Fascist movements originated in national physicians' committees."

"I think the NPC is doing a good job, but organized medicine has not been aggressive enough or offered a satisfactory alternative to the Wagner program. Certain areas do not receive adequate care. Socialized medicine in some form will be thrust upon us unless we adopt a constructive platform."

Question Box

IF you would like to know the answer to some question relating to the non-scientific (economic or personal) side of medicine, address it to the Question Box, Medical Economics, Rutherford, N.J. If the answer would be of interest to physicians generally and thus justify the research needed to get it, a member of the magazine's research staff will be put to work on it and the results will be published in an early issue. Such questions may relate to problems connected with relocation, insurance, patient relations, postwar planning, medical education, hospital activities, records, industrial medicine, law, office management, investments, office layout, group practice, etc.

When Is It Lawful to Operate Without Consent?

The answer isn't as clear-cut as might be supposed

Operation without consent is a trespass. It constitutes a technical assault and renders the operating surgeon liable.

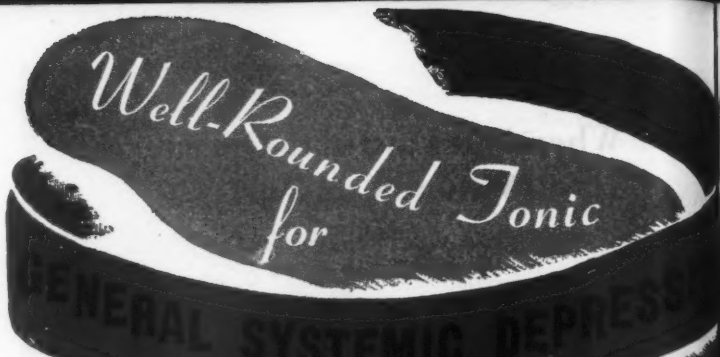
Only the operation specifically consented to may be performed, unless the need of further surgery, essential to the life or health of the patient, becomes apparent during the operation for which consent was given. No separate, unrelated, or entirely different operation may be undertaken.

In a case not long ago surgery was undertaken to correct a stiff finger. During the operation it was found necessary to utilize fascia to sheathe the tendons; this was obtained from the thigh of the patient. The surgeon was held liable.

In another case the plaintiff asserted that while he was under an anesthetic for the purpose of an examination the surgeon passed a filiform bougie into the bladder, which looped there and could not be withdrawn, and that the surgeon, without authorization or consent, then operated. Judgment was given for the surgeon. The court said that it is settled that a surgeon may lawfully perform, and it is his duty to perform, such an operation as good surgery demands in an emergency without obtaining the consent of the patient.

In the course of another operation a surgical needle was lost in the abdomen. The incision was closed. X-ray disclosed the needle in the pelvic cavity. The abdomen was reopened and the needle removed. On the second day after the operation the patient died from pulmonary embolism. The patient's husband contended that the second incision was an operation without consent and that there was no emergency. The court held that unexpected conditions encountered in the course of an operation must, generally, at least, be met according to the best judgment and skill of the operating physician; that removal of foreign bodies, unless left in the patient's body for a proper purpose, has been held to be part of an operation; that, in the present case, it could not be said that the re-opening of the abdominal incision, in order to remove the needle left there, constituted a separate operation. [*Continued on page* 83]

▶This article, which approximates a portion of the author's book, "Medical Malpractice" (C.V. Mosby Co.), explains, by precept and example, how to avoid situations that may lead to lawsuits.



In conditions of debility and systemic depression, a good metabolic stimulant may be all that is needed to renew vital function. Since time immemorial, various remedies have been offered for their tonic influence. These roborants were qualified according to the organ or system upon which they acted.

THIST is a *general* tonic which provides in a comprehensive formula stimulating agents which together invigorate the whole body and help restore well-being. Phosphorus or compounds containing this element have long been regarded as a good source of vital energy. Endocrine extracts, particularly thyroid, heighten metabolism. Strychnine has been used extensively as a nerve tonic. Iron, of course, helps to counteract anemia — so frequently a part of debilitated states.

COLE *Chemical Company*

3721 Laclede Ave., St. Louis 8, Mo.

A patient in Minnesota consulted a doctor about difficulty with her right ear. The doctor advised operation upon the ear, which was consented to. While the patient was under anesthetic, the doctor examined the left ear and found it in more serious condition than the right. He thereupon operated upon the left ear. The court held that there was no express consent; that whether consent could be found to be implied was a question for the jury; that if the operation was not authorized, expressly or impliedly, it was wrongful and unlawful.

In a New Jersey case, however, where the patient had authorized an operation for a left-sided hernia, the surgeon, finding a more serious hernia on the right side when the patient was under anesthesia, operated upon that side and was held not liable. The court said public interest requires that the surgeon be permitted to exercise his discretion in good faith.

A surgeon employed to operate on the septum of a patient's nose, removed the patient's tonsils. The basis for suit was that the operation performed was unauthorized. There was no allegation of negligence. The Supreme Court affirmed a judgment for the plaintiff.

A patient consented to an operation upon the great toe with the express understanding that no bones would be removed. A sesamoid bone was removed. This was held to constitute a trespass and a technical assault and battery.

Consent to operation may be obtained from the individual, if an adult and in a clear state of mind. The consent of a person *non compos mentis* is no consent at all. The consent of the one who stands in the position of guardian to such a person is required for an operation—except, of course, in case of an emergency.

Oral consent is sufficient, but, owing to the difficulty of proving that it was given, consent should invariably be required in writing and witnessed. The consent should specifically and unequivocably authorize the surgery which is to be performed. Blanket consent forms, which purport to authorize the surgeon to undertake any and all surgical procedures, are undesirable.

Where an operation is made compulsory by law, such as vaccination or sterilization, the law furnishes the consent. On the other hand, consent to an operation which is unlawful absolves the surgeon from neither criminal nor civil liability.

In case of operation upon husband or wife, the consent of the one being operated upon is sufficient. However, in an operation upon either husband or wife likely to result in sterility, it is desirable to secure the written consent of both the husband and wife.

If the patient is a minor, consent to operation must be obtained from the parents or guardian. In a jurisdiction where the parents are held to have equal custody, the consent of one parent is sufficient. When there has been a legal separation, consent should be obtained from the parent who has the custody of the child.

Who is a minor? The question will be answered somewhat differently in the several jurisdictions. Section 25 of the California Civil Code provides as follows:

"Minors are all persons under 21 years of age; provided that this section shall be subject to the provi-

sions of the titles of this code on marriage and shall not be construed as repealing or limiting the provisions of section 204 of this code; provided, further, that any female who has contracted a lawful marriage and is of the age of eighteen or over, shall be deemed to be of age or majority and to be an adult person for the purpose of entering into any engagement or transaction respecting property or her estate, or for the purpose of entering into any contract, the same as if she was twenty-one years of age."

Section 204 says, "The authority of a parent ceases (1) upon the appointment, by a court, of a guardian of the person of the child; (2) upon the marriage of the child; or (3) upon its attaining majority."

In every case where surgery is to be undertaken and where no unusual circumstances exist (such as an unconscious patient, making consent impossible) a specific, clear, and direct permission to operation should be obtained. There should be no room for the later claim that the patient did not know what was being consented to, or that the consent was fraudulently obtained. The consent should be "understandingly" given.

In one case a surgeon told a patient that she was mistaken about being pregnant and that she had, instead, an abscess in the vagina which should be removed. The surgeon actually performed an abortion upon her. She sued and won a judgment.

In another instance, a court, referring to a blanket consent form, said. "We do not understand such agreement to constitute a consent to perform operations other than the one which the operating surgeons were engaged by the plaintiff to perform unless necessity therefor arose during the authorized operation."

It is unsafe, from the point of possible civil liability, for a physician to examine, operate on, or treat a minor child without the consent of the parent or guardian, if consent can be awaited without danger to the child. In the event that the parents refuse consent to surgical intervention in the case of a child presenting a condition threatening the child's life, health, or sanity, it may be possible to secure court intervention. The court may direct that the

[*Continued on page* 89]

surgery be performed.

In one case a tonsillectomy was performed on a child of nine. There was no consent. The surgeon was held liable. In a similar instance a tonsillectomy was performed on a boy of eleven. An adult sister had given consent. This was held insufficient.

Consent may sometimes be implied from the circumstances of the case. In an emergency, with an unconscious and unknown patient, there need be no hesitancy in undertaking indicated life-saving surgery. On the other hand, if the patient is identified and time will permit, an effort should be made to secure consent from the responsible member of the patient's family.

Even where a minor is concerned, the law presumes, in the presence of absolute emergency, constructive consent to do what is necessary to save life. It should be understood that this is not to be taken to apply to the situation wherein the patient, an adult, is conscious and refuses to consent to surgery, or to the case when the patient, a minor, is accompanied by a parent or guardian who refuses consent.

It is generally held that whether the patient consented to the operation as performed, or whether consent was implied from the circumstances, is a question for the jury to determine, under proper instructions from the court.

No case has been found in the Law Reports involving the question of consent to post-mortem caesarean section. Consent should be obtained from the husband if he is present. Even in the absence of such consent, it might well be argued that the attending physician would be under a duty to deliver the living child, of viable maturity, from the body of the dead mother. It is submitted that a physician may undertake a post-mortem caesarean section without fear of liability in any case in which it is reasonable to believe that a living and viable child may be delivered.

There are few cases in the Law Reports dealing with the question of destructive mutilating operations, performed on the live baby during the course of delivery. The few pertinent cases on record were initiated on the theory that what the physician did to effect delivery was unnecessary, or that the physician showed lack of skill and care in not anticipating and preventing the need arising and in not taking other action earlier. Obtaining an "understanding" consent is important in these cases.

It is desirable to have consultation before any mutilating or destructive procedure upon the unborn child is undertaken and in any case in which the child may be injured in delivery. Even when a crushing or mutilating operation is undertaken upon a dead fetus, in order to effect its delivery, the accusation may be brought that the fetus was living until destroyed by the procedure.

A tremendous responsibility rests upon the physician faced with the question of whether to destroy a living fetus to reduce the mass so that delivery may be accomplished. Legal justification for this procedure can be found only in the most positively established medical necessity. The physician, before proceeding to operate, should have his decision approved by one or, preferably several, consultants.

—LOUIS J. REGAN, M.D., LL.B.

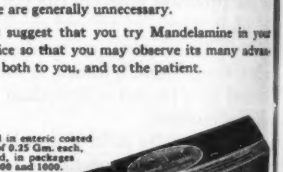
Mandelamine, by combining in a single medication the recognized effectiveness of mandelic acid as an acidifying agent and the efficiency of methenamine as a bactericidal agent, offers the physician a safe and simplified method of treatment for urinary infections.

Gastro-intestinal disturbances, so common with other urinary antiseptics, are virtually eliminated when Mandelamine is used. It is especially valuable in the treatment of pyelitis of pregnancy, where its easy toleration does much to avoid aggravation of the nausea and vomiting often associated with the gestatory period. Other conditions for which Mandelamine is indicated are pyelonephritis, cystitis, prostatitis, and the infection accompanying renal calculi.

In addition, the course of administration with Mandelamine is relatively simple inasmuch as accessory acidification of the urine, constant checking of the urinary pH, and the restriction of diet and fluid intake are generally unnecessary.

We suggest that you try Mandelamine in your practice so that you may observe its many advantages both to you, and to the patient.

Supplied in enteric coated tablets of 0.25 Gm. each, sanitaped, in packages of 120, 500 and 1000.



MANDELAMINE

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Please send me literature, and a physician's sample of Mandelamine.

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The Newsvane

180,626 New Beds

Replies to an American Hospital Association questionnaire sent to 6,400 institutions indicate that proposed non-Federal hospital construction will require a postwar expenditure of $1,193,133,985, and will provide 180,626 new beds, for a national total of 1,829,880.

Service Plan

Recently authorized by the Missouri State Medical Society, a new prepayment plan for medical and surgical care of hospitalized subscribers will be operated by the Missouri Medical Service, Inc. Benefits will be paid to patients on a straight cash indemnity basis, and will not be governed by physicians' fees. All residents of the state will be eligible for coverage.

Job Opportunities

It is not too soon to start exploring postwar civilian opportunities for medical men now in the armed services, said Dr. H. M. Baitinger, secretary of the Lake County (Ind.) Medical Society. Asserting that "there are many areas where doctors can serve and are not now serving," he recently offered the following suggestions "with the hope of stimulating further thinking" on the subject:

1. There should be room for more public health officers.

2. Some returning physicians should be able to obtain appointments as directors of hospitals.

3. There is a shortage of doctors in the practice of medicine itself.

4. There are too few anesthesiologists, and special training could prepare some demobilized men for this field.

5. There is a shortage of pathologists in hospitals, and room in many cities for the private pathological laboratory operated by a physician.

6. Many opportunities should be available in the field of epidemiology, especially for those who have gained experience in the control of tropical diseases.

7. There should be medical consultants to evaluate sickness and disability claims for insurance companies, and doctors on every workmen's compensation board to render medical judgment on the conflicting claims of employer and employee.

While these problems will have to be met locally, Dr. Baitinger stated, "there is need for a national clearing house to find opportunities and offer placement for returning doctors—perhaps a special agency established to develop new fields of opportunity."

Free Disaster Care

Members of the Harrison County (W. Va.) Medical Society have waived all fees for treatment of persons injured in the June hurricane which swept through the Shinnston area and killed seventy people. The

society's sixty-five home-front physicians also agreed to continue free treatment until all injured victims of the disaster have recovered.

Harvard Lifts Ban

Admission of women students to the Harvard Medical School is expected to be approved late this month by the university's board of overseers. The medical school faculty voted last year to admit women. The Harvard Corporation overruled this action, but recently reversed its decision.

Pediatricians Quit

Charges that the Children's Bureau of the Department of Labor "is now an active factor in the practice of medicine, dictatorially regulating fees and conditions of practice on a Federal basis," were made last month by the American Academy of Pediatrics, as it withdrew its support from the bureau.

Cited as a specific example was the administration of the EMIC program, with its payments made directly to physicians and hospitals. The AAP held that the granting of cash allotments to service men's wives, who would in turn pay the doctors and hospitals, "would be preferable since it would tend to preserve the patient-physician relationship."

While the academy admitted that "under an emergency war program" the present EMIC plan "is the most feasible," it charged that "the intent of the bureau is to enter the practice of medicine when the war is over and to continue the EMIC program under some other guise." It asserted further that the Children's Bureau planned "a free-to-all service with full-time salaried physicians, paid for directly from general taxes, and controlled and directed by a Federal bureau."

The AAP executive board announced that "the academy and the pediatricians of the United States must withdraw their support from the Children's Bureau, and use their influence to place all health activities under the Public Health Service."

In Washington, Dr. Martha M. Eliot, assistant chief of the Children's Bureau, said the "EMIC will disappear when the war is over." She denied that the bureau plans to engage in postwar practice of medicine.

Surgery at Saipan

Although the battle for Saipan produced the greatest number of American casualties in the Pacific war up to that time, less than 1 per cent of those reaching the operating table alive subsequently died.

Citing these figures, a Marine Corps report recently gave considerable credit to the high speed evacuation of more than 11,000 wounded men during the twenty-five days of the campaign, and to shallow-draft LST boats that had been converted into emergency hospital ships.

"Medical personnel from the transports were sent to these ships shortly after the landings began," the report stated. "Serious cases were dropped off at the LST's, where a full hour was saved in getting them under the knife—a move that saved perhaps hundreds of lives."

Commdr. W. C. Baty, M.C., USN. of Bessemer, Ala., senior surgeon of the Fourth Marine Division, said that while sulfa drugs and blood plasma have been the most widely

publicized "life savers" of the war, evacuation was basically a more important factor. He put it this way: Sulfa combats infection, plasma combats shock, and evacuation gets the patient on the operating table before the wound takes his life.

Rapid Treatment

"Slavish adherence" to the slower methods of treating early syphilis, despite the fact that new rapid treatments are available, has been largely responsible for failure to eradicate the disease, Dr. George W. Baehr, of the New York City Health Council, told a recent conference of state health officers and public health nurses at Saratoga Springs, N.Y.

Navy Report

The Navy's successful fight against wartime health hazards has been underlined in a report by Vice Admiral Ross T. McIntire, Surgeon General, for the year 1943. Here are its highlights:

¶ Mortality rate below 3 per cent;

¶ Venereal disease incidence lowest in forty-three years;

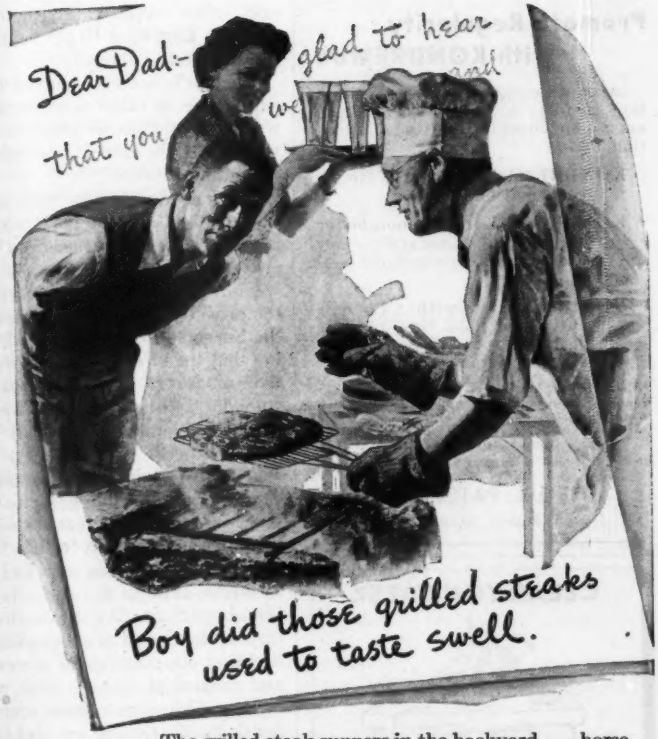
¶ No serious epidemic disease, except for a mild flurry of influenza;

¶ Steady progress in tropical disease prophylaxis.

Admiral McIntire said he was "firmly convinced that air transportation of wounded will reduce by 30 per cent our present mortality rate if we use this method for all our major combat work."

During the first twenty-seven months of U.S. war participation, he said, less than 20 per cent of Navy and Marine Corps casualties were due to illness, while 46 per cent resulted from gunshot, shell,

[*Continued on page* 100]



The grilled steak suppers in the backyard . . . horseshoe pitching with the gang . . . the friendship of a faithful spaniel . . .

These are the things that fill his letters . . . little things, small familiar pleasures, but to him as to all of us, they add up to home.

It happens that to many of us these important little things include the right to enjoy a refreshing glass of beer. Wholesome and satisfying, how good it is . . . as a beverage of moderation after a hard day's work . . . with good friends . . . with a home-cooked meal.

A glass of beer or ale—not of crucial importance, surely—yet it is little things like this that help mean home to all of us, that do so much to build morale—ours and his.

Men of the U. S. Navy say letters keep up morale . . . write that V-Mail letter today!

Morale is a lot of little things

(As you, Doctor, know better than most)

BREWING INDUSTRY FOUNDATION

and other types of penetrating wounds. Less than 10 per cent were due to combat fatigue.

"This is in marked contrast to our experience in other wars, where it was found that most hospitalization was caused by disease," commented Admiral McIntire.

He conceded that in tropical battle areas in 1943, the Navy was still beset by malaria, filariasis, epidemic jaundice, and the dysenteries. "But we have made steady progress in the prevention of all these diseases," the Surgeon General declared, adding that the effective use of preventive measures in the tropics was splendidly demonstrated by the Navy's epidemiological teams, sanitary engineers, and Seabees.

Actually, Admiral McIntire declared, "a visitor now going to Guadalcanal expresses great surprise at the tales of hardship he has heard and wonders why our men had such a terrible time in the early days of island warfare. We have cleaned up the island, and as we go along we find that our methods of prevention and control of disease work well."

Most illness casualties from the South Pacific theatre are sent to the Naval Hospital on Treasure Island, in San Francisco Bay, where a school for post-graduate teaching of tropical medicine has been established. It is staffed by well-qualified civilian practitioners from the bay area, plus a number of Naval medical officers. The Navy also expects from time to time "to invite the teaching institutions to send to this school certain members of their staffs, so that we can gain from their knowledge, and they, in turn, from what they see in this school."

Admiral McIntire expected an

[*Continued on page* 105]

"increasing number of deafness cases" resulting from wartime head injuries. While the hearing aid "is a grand crutch," he said, the deaf nevertheless "present a very serious problem."

Addressing his report primarily to America's doctors, Admiral McIntire also took occasion to discuss "the problem of decent medical care—at reasonable cost." He reiterated his opinion that this problem "should rest in the hands of the doctors," and he hoped "they will present a sound plan" for the low-salaried groups.

"If there is to be legislation by Congress, why shouldn't we take a decisive role in its drafting and sponsorship," he asked, "rather than yield to individuals who approach this serious problem from an unrealistic viewpoint?"

Rx Outlets

A 14.2 per cent increase in department-store prescription departments is indicated by the 1944 Drug Topics List Book, which reveals that there are now eighty-eight, as against seventy-seven in 1942. Currently, 319 department stores maintain packaged-medicine departments, against 292 two years earlier—an increase of 9.2 per cent. Also listed are 513 chain organizations operating three or more drug stores, for a total of 4,929. In 1942, 571 chains operated 5,237 stores.

Blue Cross Penicillin

Penicillin is now being provided without charge when required by hospitalized members of the Associated Hospital Service of New York, according to an announcement by Louis H. Pink, president, who said that "if other new and unusual drugs or services become available, their cost also, if not too great, will be met in the same manner." The AHS board of directors believes that "in addition to budgeting normal hospital expenses for its members, it should help them take advantage of new developments in medicine whenever possible."

AAPS Meets

The Association of American Physicians and Surgeons, organized last December to combat Federalization of medicine by organized non-participation, will not open a Washington office as long as the one operated by the AMA functions effectively. This was revealed at the first annual meeting of the AAPS in Chicago, Aug. 23-25. A spokesman declared that the association was much impressed with the "forward-looking work being done by the AMA Council on Medical Service and Public Relations." The council, he noted, "has included in its latest program a number of proposals made by the AAPS. Now we are willing to wait and see how well they will be implemented by the Board of Trustees of the AMA. If the AMA gets in and does an acceptable job, the AAPS will withdraw its objectives, one at a time, as the AMA takes them up."

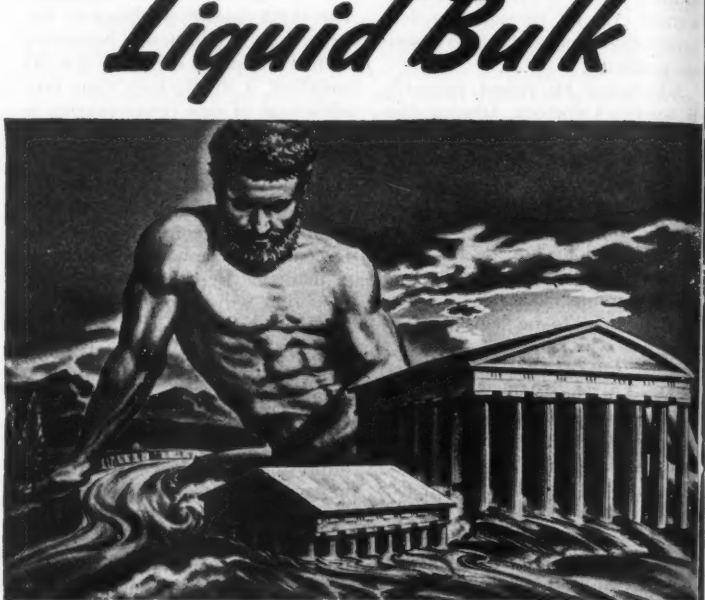
The membership of the association was reported to be growing slowly and steadily. Latest organizations to join *en bloc* include the medical societies of Cambria County, Pa., Pueblo County, Colo., and Alachua County, Fla. About a dozen societies have joined in this manner.

Replying to charges that the AAPS is a "union," its spokesman

[*Continued on page* 107]

HERCULES KNEW THE POTENCY OF

Liquid Bulk



WHEN commanded to clean the stables of Augeas, where 3000 oxen had been kept for many years, Hercules solved this stupendous problem in one day by diverting the rivers Alphaeus and Peneus to run through the waste-laden stables.

Similarly, in the intestinal tract, there is no more efficient method of flushing away waste than by the use of *liquid bulk* —as formed by Sal Hepatica plus water.

Clinical and laboratory tests prove that:

★ in the isolated loop of a dog's ileum, a laxative solution of Sal Hepatica increased the liquid bulk by 34 per cent in one hour.

★ in thistle tube experiments, a Sal Hepatica solution increased the liquid bulk by 100 per cent within 6 to 12 hours.

★ Sal Hepatica's liquid bulk helps stimulate bowel muscles, maintain a proper water balance. And the salines of Sal Hepatica relieve gastric acidity, promote the flow of bile.

Bristol-Myers Company, 19-11, West 50th St., New York 20, N. Y.

TO HELP FLUSH THE INTESTINAL TRACT

Sal Hepatica  **Liquid Bulk!**

declared that "The term implies a willingness to strike against the employer. We are not a union, because we refuse to desert our employer—the patient—in favor of a bureaucracy." He revealed that the controversial 75 per cent rule—whereby members are pledged not to cooperate with non-members when the AAPS has enrolled three-quarters of the physicians in a community—would not be invoked except in a definite emergency. He added that such an emergency would exist, for example, if non-members participated in a program set up under the Wagner-Murray bill or under similar legislation.

Control of Fees

Warning against attempts of lay organizations to control medical fees, the state medical societies of Washington, Oregon, and Idaho have jointly urged the medical profession as a body to "take a determined stand for the right of establishing its own fee schedule for medical services." The statement asserted that a number of "associations selling hospital privileges have included fees for medical attendance which have been set without consultation with the attending physicians."

Medical Expedition

Liberation of Holland by the Allied armies will be followed by an American "medical education expedition" to give a series of four-week post-graduate refresher courses in Dutch universities, it was announced recently by the Netherlands Information Bureau.

Courses covering eight specialties have been prepared in both English and Dutch by a group of physicians recruited from American medical schools and hospitals. Traveling and personal expenses will be paid by the Netherlands government, but the instructors will receive no special compensation for their work in Holland. Because of German looting of Dutch equipment during four years of Nazi occupation, the teachers will take with them all material and instruments needed for laboratory and demonstration purposes.

The expedition will include Dr. Wilburt Davison, dean of the medical school of Duke University; Dr. Isidore Snapper, director of the department of graduate medical education at Mount Sinai Hospital, New York City; and Dr. D. D. Van Slyke, of the Rockefeller Institute.

Compulsory Check-ups

As "one who fears the encroachment of Federal agencies into the sickroom," Mrs. Walter Ferguson, featured Scripps-Howard writer, recently suggested another approach to the problem of public health. Said she:

"The Government, it seems to me, could do wonders by making it compulsory for every citizen to have a physical check-up at stated intervals. And why not? We are forced by law to have our automobile brakes looked after at certain times. A check-up for physical symptoms is just as sensible.

"Besides, socialized medicine won't improve public health unless you can persuade the people to use its services—which they won't if they run true to form. The average man never consults his doctor until he's half dead, and the chances are he wouldn't consult a Government

[*Continued on page* 110]

Simplicity of Application

• A contraceptive method, to be effective, should combine *simplicity* of application with *demonstrated* spermicidal activity.

Lygel Vaginal Jelly (with patented applicator) provides such a method —with or without the use of a mechanical barrier.

The *Jelly-alone* method was used in the Public Health Clinic of a southeastern state for a period of 16 months, resulting in an *effective* reduction of fertility.

The result of these tests, together with other informative data, will be mailed to interested physicians on request.

Lygel Vaginal Jelly is non-irritating and non-injurious in continued use. It is available in slip-label packaging for ethical dispensing and is promoted through the medical profession.

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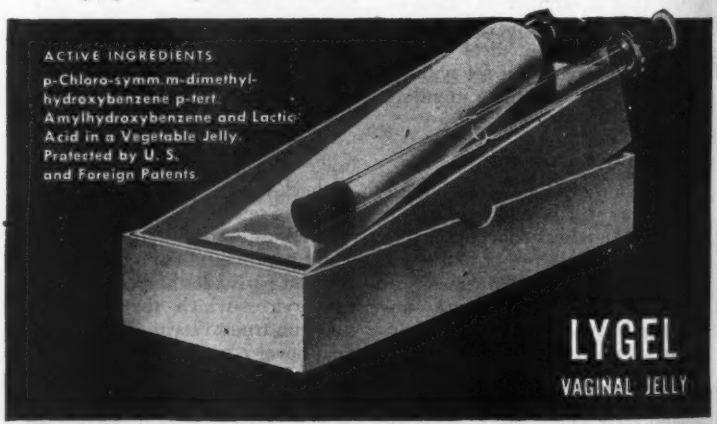


"Lygel" Reg. U. S. Pat. Off.

TO OVERBURDENED DOCTORS:

May we be of assistance to you in cases requiring mechanical relief and correction of

FOOT TROUBLE?

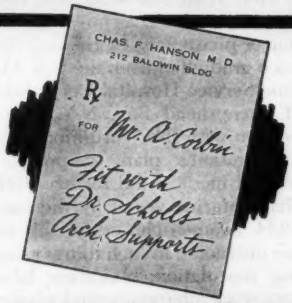
WE are thoroughly alive to the extra burdens the war effort is calling upon you to assume.

At your disposal is our thoroughly organized and highly developed Dr. Scholl's National Foot Comfort Service, prepared to relieve you of as many cases of foot trouble as you may care to entrust to us.

This service is based on the 30 years of practice of Wm. M. Scholl, M.D., Chicago, as a consultant in deformities and diseases of the feet, and his wealth of unique experience in designing and formulating scientific Appliances, Arch Supports, Treatments, Shoes, etc. for relieving and correcting foot ailments.

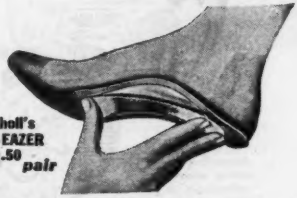
Dr. Scholl's Foot Comfort Service is available at many Shoe, Department Stores and Surgical Supply dealers and at all Dr. Scholl's Foot Comfort Shops in principal cities.

Please mail coupon below for address of your local or nearest Dr. Scholl's Foot Comfort Service Depot, and our Professional literature, specially written for the Physician.



A simple prescription like this suffices to assure your patient being given the required relief.

Dr. Scholl's Pedograph, instantly and graphically reveals the existence of foot arch weakness, its nature and degree.



Dr. Scholl's FOOT-EAZER $3.50 pair

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Please send me address of your local or nearest Dr. Scholl's Foot Comfort Shop and your literature specially written for the Physician.

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agency with any better regularity.

"Why not sensible cooperation? The Government can order the people to see their doctor for a free check-up—and let the doctor take over from there."

Medical Aid for Seamen

More than 1,200 "medical representatives," rated as junior assistant purser-pharmacist's mates, have been graduated from the U.S. Maritime Service Hospital Corps School at Sheepshead Bay, N.Y., in connection with the War Shipping Administration's plan to provide a trained medical aid for every Merchant Marine vessel by the end of 1944. Seamen chosen for this work are instructed in such things as nursing, inoculation, sanitation, laboratory work, pharmacy, and advanced first aid. This curriculum is supplemented by one month's training and practical experience in an approved hospital.

Illinois Plasma Plan

Detailed information about the Illinois plasma program, recently made available, shows how that state's department of health makes blood plasma available to Illinois hospitals. Here are the plan's principal features:

¶ The health department deposits with a hospital sufficient plasma to treat several patients, the quantity being determined by the size and potential needs of the hospital.

¶ The hospital agrees to replace promptly any of this plasma it uses, doing so in one of the following three ways:

[*Continued on page* 114]

Development attack on SPASM

Searle Research follows up its introduction of the safe, non-narcotic, antispasmodic Pavatrine with the new *three-fold-action* product . . .

pavatrine with phenobarbital

CLINICAL ADVANTAGES: *Increased and more prolonged spasmolytic action* provided through addition of mild central nervous sedation (phenobarbital) to the pronounced musculotropic and neurotropic antispasmodic action of Pavatrine.

INDICATIONS: Gastrointestinal spasm, dysmenorrhea, urinary bladder spasm.

• Each sugar-coated tablet contains 125 mg. (2 gr.) of Pavatrine (Searle) with 15 mg. (¼ gr.) of Phenobarbital. Supplied in bottles of 100 and 1000 tablets.

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ETHICAL PHARMACEUTICALS SINCE 1888
CHICAGO
New York Kansas City San Francisco

1. By outright purchase of plasma processed in a laboratory approved for the purpose by the National Institute of Health.

2. By collecting from relatives or friends of the patient sufficient blood to replace the plasma, and shipping it to Chicago for processing, the cost of the latter being borne by the patient, hospital, or community.

3. By collecting and shipping for processing enough blood to yield twice the amount of plasma needed for replacement, whereupon there is no charge for processing.

Care for Migrants

Medical care may be provided for migratory farm laborers in Midwestern states by local physicians on a fee-for-service basis, under the terms of the War Food Administration's program of assistance in food production. No restrictions would be placed on free choice. Physicians, dentists, and hospitals would charge fees comparable with those charged the medically indigent, and be paid out of tax funds.

Provision of such care is one of the general objectives of an industrial hygiene and medical program for migrant workers, operated by the health services division of the WFA office in Chicago, which serves seventeen states.

Other objectives are importation of healthy farm workers; prevention of the spread of disease by workers; provision of sanitary housing; and promotion of optimal health in the individual in order to reduce absenteeism, promote morale, etc.

Group Trend

The war has given new impetus to the trend toward group practice, in the opinion of Lt. Col. Basil MacLean, M.C., medical director of Strong Memorial Hospital, University of Rochester.

"The advantages of professional teamwork have been demonstrated to thousands of medical men in the armed forces," he told a recent hospital assembly in Chicago; "and many believe that in civilian life these advantages may be offered by group partnership without appreciable loss of individual independence. Already there is a trend among some hospital staff members toward the organization of sections of the staff for this type of practice."

Colonel MacLean also envisaged a postwar "increase in the number of hospital appointments on a salaried, full-time or part-time basis in many of our voluntary hospitals." He said "the request for such a development will come from the clinical members of the professional staff of hospitals, and not only from the members of laboratory and other ancillary departments."

China's Medical Setback

Japan's war of conquest brought about a serious setback to medical progress in Free China, it was pointed out recently by Dr. Wilder Penfield, professor of neurology and

neurosurgery at McGill University, Montreal. Dr. Penfield observed conditions during a visit to China in 1943.

Prior to the invasion, he said, the Chinese had been abandoning their ancient forms of medical practice, and their government was initiating ambitious construction of university medical schools. But with the Jap attack and the loss of seaboard cities, the government closed twenty-eight out of twenty-nine medical schools.

V.D. Control

Private physicians have been playing a significant part in the success of a venereal disease control program in Philadelphia, sponsored by the department of health and the Philadelphia County Medical Society.

"No overcrowded system of clinics could be expected to bear the strain [of treating tens of thousands of cases uncovered by wartime blood tests and military controls] without enormous and almost unheard of expansion," a recent joint report said, adding that the "improved economic circumstances of many patients seeking medical care for gonorrhea and syphilis has made it evident that more and more individuals can afford the full cost of treatment."

Summarizing efforts "to bring about a fuller utilization of private medical practice in the treatment of venereal disease patients," the report pointed out that

¶ Private treatment of syphilis in Philadelphia has increased 86 per cent since 1940 (gonorrhea, 30 per cent);

¶ Publication of a bulletin listing 1,164 physicians willing to examine and treat V.D. patients privately has resulted in a 44 per cent increase in the number of physicians caring for such cases, plus an increase in the average number of V.D. patients per physician.

Aid for M.D.'s

A continuous, non-commercial drug exhibit for the thousands of doctors who visit its library each year has been arranged by the New York Academy of Medicine. An attendant is prepared to answer questions and explain new drugs. The program, which includes the distribution of pamphlets and literature describing the products exhibited, as well as data on their research and clinical usage, is under the guidance of a physicians' group working with an advisory committee of drug manufacturers.

Limiting Specialists

Declaring "it would be a calammity" to have two specialists where only one is needed, Dr. Robin C. Buerki, dean of the Graduate School of Medicine, University of Pennsylvania, suggested recently that "for the good of the individual physician and the patient, we should not make too many residencies available."

He declared that just prior to the war, between 75 and 80 per cent of students hoped and planned to enter specialties; yet only about 20 per cent of the medical profession now limit practice to special fields.

"Today, the specialty boards fail from 15 to 40 per cent of the physicians who appear before them," Dr. Buerki said. "It is unfair of us to offer a residency to a man if, at the end of three years, he fails his specialty board because of inadequate preparation. Too few hospitals are able to offer him adequate

THE RELIEF ROLE OF "MOIST HEAT"

MANY authorities advise the use of moist heat in the form of poultices for relieving the following symptoms when present in affections of the respiratory system:

- **COUGH**
- **RETROSTERNAL TIGHTNESS**
- **MUSCULAR AND PLEURITIC PAIN**
- **SORENESS OF THE CHEST**

Antiphlogistine as a medicated poultice provides a convenient method for applying moist heat for prolonged periods.

Antiphlogistine is valuable as an adjuvant in the symptomatic treatment of Bronchitis, Tracheitis, Chest Colds, Tonsilitis, Pneumonia, Pleurisy.

Antiphlogistine may be used with Chemo-therapy.

Antiphlogistine

Formula: Chemically pure Glycerine 45.000%, Iodine 0.01%, Boric Acid 0.1%, Salicylic Acid 0.02%, Oil of Wintergreen 0.002%, Oil of Peppermint 0.002%, Oil of Eucalyptus 0.002%, Kaolin Dehydrated 54.864%

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And Your Favorite Sizes Are Now Available

Your surgical instrument dealer is now in position to supply you with the needle favored by thousands of physicians and surgeons for Intramuscular work—the Square Hub VIM.

This is the needle made from genuine Stainless *Cutlery* Steel; the needle with the hollow-ground point and razor-keen cutting edges that gently slit rather than puncture the tissues. Most important, VIM points hold their sharpness despite continued use and sterilization; they are heat-treated and uniformly tempered to exactly the hardness necessary in a "precision" instrument to assure long-lasting service. If it's VIM, it stays sharp indefinitely.

The following lengths and gauges are now in ample supply; order from your surgical instrument dealer:

20 gauge, in lengths 1" 1¼" 1½" 2" 4"
21 gauge, in lengths 1" 1¼" 1½" 3"
22 gauge, in lengths 1" 1¼" 1½" 2"

Write us for the complete list of VIM Stainless *Cutlery* Steel Needles for general Hypo use, for Intravenous, Intradermal and Subcutaneous work.

FIRTH STAINLESS *CUTLERY* STEEL HYPO NEEDLES

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training in physiology, anatomy, pathology, biochemistry, physics, etc.

A hospital may have excellent residencies for three men in general surgery, but if it attempts to expand the program and accept six men, it is possible none of the six will get the quality of training that he should have."

After the war, Dr. Buerki said, hospitals that cannot offer internes a satisfactory educational program "should replace them with paid house officers who have completed their interneship. Pay these men to do the type of work wanted. Pay them adequately. One such man, well-trained, will do the work of two internes; therefore, pay him the equivalent in salary and maintenance of two internes. The hospital will have much more satisfactory service."

Weighing training generally, Dr. Buerki sees "three separate and distinct phases in the educational life of a doctor":

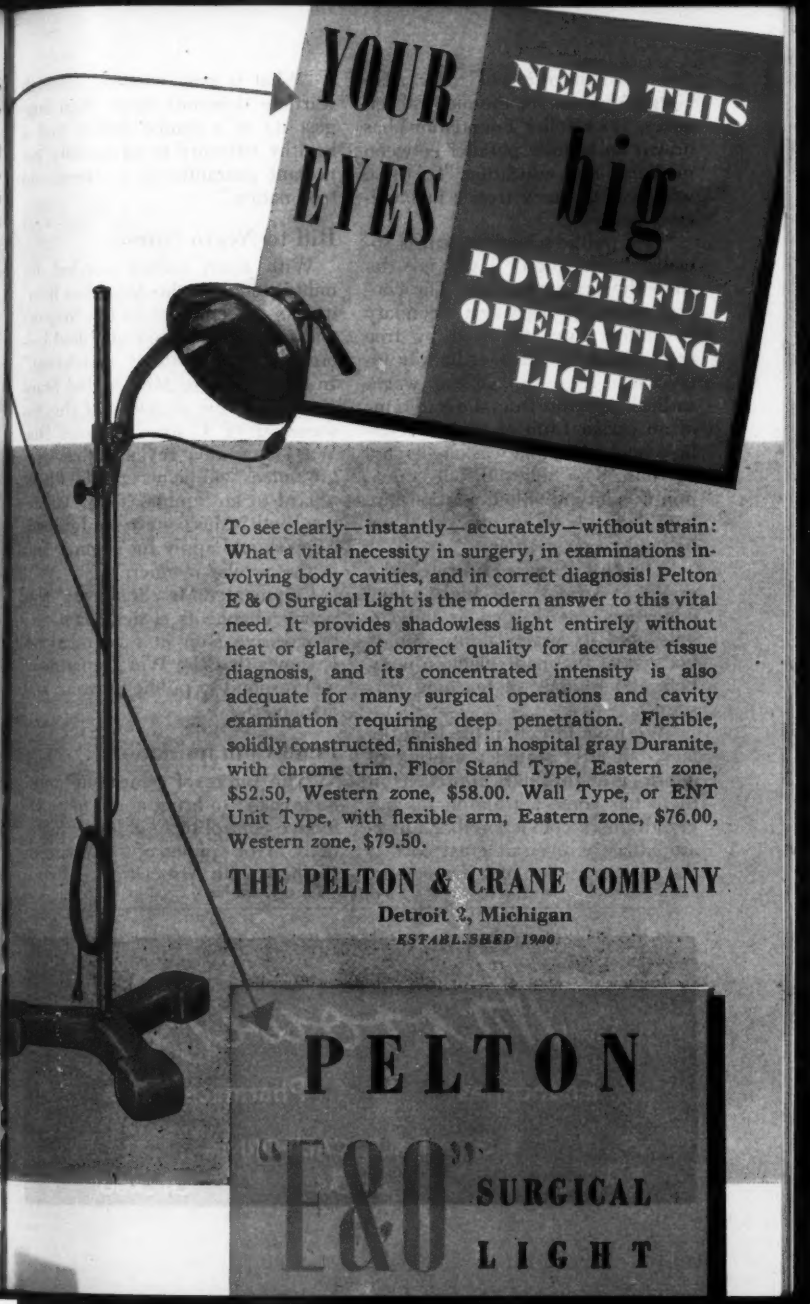
1. Undergraduate education, including the traditional four-year course in medical school plus an interneship;

2. Graduate education, embracing long, continuous courses of study, designed to qualify an individual for one of the specialties;

3. Post-graduate education, consisting of short periods of study, aimed at keeping the general physician or the specialist abreast in his field, but not designed to prepare him for any special branch of practice.

Parallel by Gregg

First putting his own position on record ("I do not want the private practice of medicine to disappear



To see clearly—instantly—accurately—without strain: What a vital necessity in surgery, in examinations involving body cavities, and in correct diagnosis! Pelton E & O Surgical Light is the modern answer to this vital need. It provides shadowless light entirely without heat or glare, of correct quality for accurate tissue diagnosis, and its concentrated intensity is also adequate for many surgical operations and cavity examination requiring deep penetration. Flexible, solidly constructed, finished in hospital gray Duranite, with chrome trim. Floor Stand Type, Eastern zone, $52.50, Western zone, $58.00. Wall Type, or ENT Unit Type, with flexible arm, Eastern zone, $76.00, Western zone, $79.50.

THE PELTON & CRANE COMPANY

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ESTABLISHED 1900

PELTON

"E&O" SURGICAL LIGHT

nor do I believe it will"), Dr. Alan Gregg, director for the medical sciences, Rockefeller Foundation, has drawn an historic parallel between medicine and education. To those who fear the new trends in medicine, he says:

"Our public-school system is socialized education. It did not destroy the private schools. The concept of free primary and secondary education, later followed by free universities, was extraordinarily inclusive in its sweep. It, too, was a radical departure from the traditions of an earlier form of society. Public-school education was challenged by those who believed that education was an individual relationship, had always been so, and could not be made a mass affair.

"The cost of giving every child a grammar school and high school education was decried as unbearable, and its practicability denied because of the inadequacy in numbers and training of teaching personnel.

"We have forgotten the long delays, but after almost a century of effort, growth, and improvement there has come a triumph for our grandfathers' conviction that a literate citizenry, even at great cost, is the best guarantee of a democracy.

"What is now wanting (though wartime demands more than suggest it) is a similar belief that a healthy citizenry is an equally important guarantee of a strong and free nation."

Bid to Negro Nurses

With more nurses needed for military service, the Army has lifted its ban on commissions for Negroes and is now accepting qualified colored nurses "without restriction." In a telegram to Mrs. Mabel Staupers, executive secretary of the Association of Colored Nurses, the War Department revealed that "Negro nurses will be accepted without regard to any quota. They will be used both in this country and abroad. They should apply for commissions in the regular manner."

Commented Mrs. Staupers: "This policy change is a significant and progressive step in race relations. It shows that the War Department will respond to public pressure and demands."

Food Contamination

"The forces of education" must be invoked to bring about more effective control of food-borne infections, in the opinion of the American Public Health Association. "The re-

Safe Hypotensive for Long-Continued Use

NOT all advertising slogans have meaning or significance. Believe it or not, some are adopted for no worthier reason than because of their lilt or euphony.

However, in the "slogan" that heads this message lies the distinguishing feature of ALLIMIN—Concentrated Garlic-Parsley Tablets—one of the most widely-prescribed of all hypotensives now available to the physician.

Though every therapeutic agent that may properly be called a "hypotensive" must, by that token, lower high blood pressure, of few, other than ALLIMIN, may it truly be said that they are

SAFE for Long-Continued Use

ALLIMIN is free from toxicity—free from undesirable side- or after-effects of any kind.

Besides lowering elevated blood pressure in more than 80% of cases, as disclosed by carefully controlled clinical investigation and corroborated by the reported experiences of practicing physicians in considerable number, ALLIMIN gives relief from the more distressing symptoms associated with hypertension, headaches and dizziness, in almost 100% of cases. Each enteric coated ALLIMIN Tablet contains 4.75 gr. dehydrated garlic concentrate and 2.37 gr. dehydrated parsley concentrate. For professional sample and monograph on hypertension, just sign and mail the coupon.

NEWLY PUBLISHED —

Concise, informative, authentic, this 32-page monograph, "The Therapeutic Use of Garlic Concentrate in Hypertension," deals with medical and economic phases of hypertension, its etiology, general and specific therapy, etc. It gives a good yardstick for measuring hypotensives, contains much information not available in any other form, and has an exhaustive bibliography on hypertension that makes it a valuable addition to every physician's library. Available to physicians on request.

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500 N. Dearborn Chicago 10, ME-9

Please send monograph on hypertension and sample of ALLIMIN.

Dr. _____

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Town _____ State _____

turn from African and South Pacific service of hundreds of thousands of carriers of the germs of amebic and bacillary dysentery will make this problem one of major significance in the next few years," it asserted last month, adding that neither the medical approach nor law enforcement, however helpful, can insure effective control. The APHA suggests that the "ideal" method ("an inspector on the ground every day and every hour of the day") can be approximated by educating food handlers and enlisting them as "informal deputies" to detect deviations from sanitary practice.

No Privy

Census Bureau figures indicate that "a large part of the American public is not served by modern sanitary conveniences." According to M. Allen Pond, sanitary engineer of the Public Health Service, 48.8 per cent of the 37,325,000 dwelling units in the United States in 1940 either needed major repairs or lacked inside toilets or baths. In this category were 81.8 per cent of the 13,640,000 rural dwelling units and 29.9 per cent of the 23,685,000 urban units. In the rural areas, 940,000 homes had neither a toilet nor a privy.

Pregnancy in Industry

Some 300,000 married women who are civilian employes in more than 1,000 Army operated industrial plants, are now covered by a maternity aid plan recently inaugurated by the War Department. They include clerical workers, and represent, in all, 60 per cent of the more than 500,000 women civilian employes of the War Department.

[*Continued on page 128*]

The program was worked out by the Surgeon General's office according to standards recommended by the Children's Bureau and the American Medical Association. Civilian personnel officers of the Army have been instructed to this effect:

No employe should be asked to resign because of pregnancy; if it proves impossible to utilize her services, she should be granted maternity leave up to one year; the pregnant woman's personal physician or the plant medical officer must be consulted on her work assignment, and a transfer granted if a job is unsuitable to her condition.

The following modifications of employment rules, when deemed advisable by an Army post surgeon, an industrial medical officer, or a family physician, are to apply to the pregnant War Department employe:

¶ She may not continue at work after the thirty-second week of pregnancy.

¶ She may not return to work until six weeks after delivery, and then only with the approval of her physician.

¶ When pregnancy is determined, the employe is to report her condition to the industrial medical department, in order that she may receive proper supervision and be safeguarded in her work.

¶ A pregnant employe is to report to the medical industrial department every two weeks, at which time the nature of her work and hours of employment will be scrutinized. If she displays any unfavorable symptoms, they are to be reported to the employe's physician by the post surgeon, industrial medical officer, or plant nurse.

¶ Plant managers are to remember that it is not advisable to employ pregnant women between midnight and 6 A.M., or for more than forty-eight hours a week. Where possible, two ten-minute rest periods are to be arranged during each work shift.

¶ Pregnant women are not to be assigned to work requiring heavy lifting or strain, nor to work which, in the opinion of the industrial medical officer or the employe's family physician, would constitute a hazard to her.

As the War Department announced its plan, the Children's Bureau said there were indications that many private industrial plants were still pursuing a short-sighted policy on the question of pregnancy.

In a three-month study made by the bureau in seventy war plants in eleven states, most plants were found to have a pregnancy policy which the bureau regarded as pointless and dangerous. Of sixty-two plants with an established policy, half ended employment on pregnancy—nineteen dropping the employe outright and the rest setting up some form of leave-of-absence arrangement. The thirty-one other plants ended employment at some specified month, ranging from the

second to the eighth.

While the plants sought in this way to avert the dangers of abortion, the Children's Bureau reminded them that the greatest danger lies in the first two months, when pregnancy may not be known. After that, it said, women may as well go on working for the safer third to sixth months. Dismissals for pregnancy, the bureau added, tended to cause women to conceal their condition.

Contrasting with the new Army plan were the findings of a recent survey by Modern Industry indicating that abortion was a serious menace in those plants that discharge pregnant women even when their jobs are non-hazardous until within a few weeks of parturition. Actual or potential loss of womanpower in industry was also described to the birth of unwanted babies, and the lessened efficiency of married women deprived of a normal sex life through fear of conception.

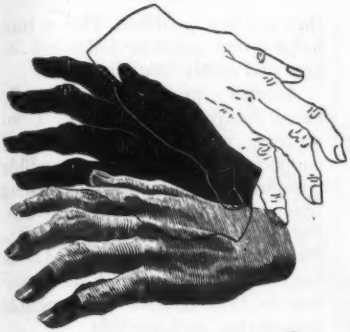
While some employers were found who encouraged the birth of healthy babies to healthy mothers by liberal policies, others were said to shy away from the problem of conception, maternity, and abortion. Modern Industry saw this as posing the problem of whether management should become, "directly or indirectly, the medium for spreading knowledge on planned parenthood—child spacing, or what was once called birth control."

Cited as having boldly met the challenge—by giving child-spacing education to its women employes—was a Southern textile plant. At one time, an average of from six to twelve women left their jobs each Friday, had "therapeutic abortions legally performed in a nearby city," and returned to work Monday morning.

In this plant, the personnel department is now providing all married women with information about child spacing. "They undergo complete pelvic examinations, are fitted for vaginal diaphragms, and taught the use of contraceptive jellies," said the report.

"Company literature throughout stresses the fact that this is not a program to prevent conception for all time or to promote promiscuity; rather is it management's attempt to help women workers protect their health and build better families by having children when they're wanted.

"The pelvic examinations, incidentally, have aided this company in placing women in jobs for which



HELP FOR ARTHRITICS

Many investigators report colloidal sulfur therapy is a valuable aid in relieving pain and swelling in chronic arthritis.

Sulphocol

MULFORD COLLOID LABORATORIES

MANY clinical reports show that among the remedies used in the treatment of arthritis, colloidal sulfur is frequently employed and highly satisfactory results have attended its use.

SULPHOCOL offers all the advantages of colloidal sulfur therapy and in addition improves the general defensive mechanism of the body— two widely used types of treatment. SULPHOCOL aids in the reduction of joint swelling and thus lessens pain, and usually prevents or minimizes further joint involvement.

SULPHOCOL has been used with satisfactory results in thousands of arthritic cases. The accumulated literature and clinical experience provide ample proof of the efficiency and safety of this type of therapy. It is well adapted to ambulatory treatment. Gastro-intestinal disturbances and other undesirable side-reactions do not occur.

Available in two forms: SULPHOCOL SOL, for parenteral use. SULPHOCOL, in capsules for oral administration.

For more detailed information, write to The National Drug Company, Dept. I, Philadelphia 44, Pa.

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BIOLOGICALS, BIOCHEMICALS, PHARMACEUTICALS FOR THE MEDICAL PROFESSION

they are best qualified. This in turn helps avert possible industrial injury and costly litigation."

Another problem purportedly faced by personnel managers, industrial nurses, physicians, and counselors is an almost incredible ignorance among women regarding the natural functions of their bodies. For one thing, unwarranted job absenteeism was often found due to ungrounded fear about menstruation or to overstrain at unsuitable jobs during such periods.

Fee Splitting

The New York Academy of Medicine took steps last month to request the immediate resignation of nine of its fellows, accused of fee-splitting in workmen's compensation cases, after it had found that "the suspicion of guilt was strong" against them. They were among fellows granted hearings by an academy committee when their names appeared in the press in a list of doctors accused by Moreland Commissioner Herman T. Stichman, following his recent investigation. The committee found that "while there was a basis for suspicion of guilt in some but not all of the cases examined, legally competent proof of guilt was not available.

"To contribute further to the abatement of the reprehensible practices of fee-splitting and rebating, the academy once again affirms its condemnation thereof," its announcement stated.

The academy's constitution was also to be amended to eliminate what a spokesman called "loopholes" in its provisions against fee-splitting. Further, it was voted to require applicants for membership to

[*Continued on page* 136]

sign this pledge: "The undersigned hereby agrees to accept the council of the academy as the sole and only judge of his qualifications to remain a fellow."

Medicine at Cassino

Some of western civilization's earliest contributions to medical science stem from the famous Benedictine Monastery on Mount Cassino which was destroyed in the bitter war on the Italian peninsula.

Recalling that the first medical university of Europe, the School of Salerno, had its beginnings in the abbey, Dr. Leopold S. Vaccaro describes it in the Medical World as a "sort of Rockefeller Foundation of the Middle Ages." Besides their religious duties, he says, the monks "were enjoined to apply themselves to science and general literature and to engage—by payment of liberal salaries—the most learned men."

But the abbey suffered many misfortunes over the centuries. Only sixty years after its foundation by St. Benedict in 528 A.D., it was destroyed by Zoto, the Lombard Duke of Benevento, and was not rebuilt for 130 years. In 884 it was burned by the Saracens. In 1045, however, when the Normans tried to take possession of the abbey, its monks laid down the pen and took up the sword with sweeping success.

With all its tribulations, the monastery increased—century by century—in power and prestige. Medicine in particular engaged the attention of its monks. Eminent in medical history is the abbot, Bertharius, who wrote two books on medicine before he fell in the Saracen raid. Alfanus II, elected abbot in 1057, wrote medical treatises on the union of the soul and the body. But it was with the arrival of Constantine the African, *circa* 1075, that the abbey entered its golden era.

Constantine was born in Carthage. After thirty-nine years of study and travel he returned to his native country, master, it is said, of all the learning in the world of his time. He was particularly proficient in medicine—so much so that he excited the jealousy of his rivals, and was obliged to flee to Mount Cassino for refuge.

"Having been converted to Christianity," says Dr. Vaccaro, "he became a monk, and retired to the monastery. By his wonderful cures, the multitude of books he wrote, and the number and fame of his scholars, he raised the reputation of the School of Salerno to its greatest height. Some of his works have been printed; oth-

ers remain in manuscript."

Another noted physician of that period was Gariopontus, author of the encyclopedic *Passionarium*. Much of the material in it was based on the writings of Galen, Theodorius, Alexander, and others. Dr. Vaccaro terms this work the "basis of modern medical language."

Before Salerno, the teaching of anatomy had been based on the dictums of Galen. But on Mount Cassino dissection replaced empiricism. Surgery, too, was greatly advanced, especially by Ruggiero di Frugardo, whose *Post Mundi Fabricans*—a classical textbook for several centuries—treats of the wounds of the head and brain, and gives the differential diagnosis of the lesions of the cranial bones and indications for trephining.

In 1231, the abbey decreed that students complete a three-year study of logic before beginning the five-year course in medicine. Even after this extended study they were not licensed until they had practiced for a year under an expert physician.

A student was admitted to the doctorate by the ceremony of placing a book in his hands, a ring on his finger, a crown of laurel on his head, and a kiss on his cheek. "Then," Dr. Vaccaro continues, "he took an oath to observe the regulations respecting medicine, to inform the courts if the apothecaries did not prepare drugs properly, and to give advice to the poor gratis. Every physician had to visit a patient at least twice a day and once in the night if necessary." For his attendance he received an established fee. No doctor could undertake to cure a disorder for a specified sum.

Speaking Frankly

[*Continued from page* 20]

that is the only way to get the work done. If the trend toward collectivism continues, medicine will have to fall in.

R. Taunton, M.D.
New York, N.Y.

Restrictions

Your article on statement forms was a good one, but I'd like to call your attention to an error: the statement that "Physicians generally seem to order a good quality paper (*e.g.*, 24-lb. rag-content white)."

I'd say that nine out of ten statements (as well as other professional stationery forms) are printed in normal times, on 20-lb. bond paper, and seven out of ten on a No. 1 sulphite. Today, due to Government restrictions, the use of any paper heavier than 16-lb. bond is prohibited. (The only exceptions, under the regulations, are 75 and 100 per cent rag papers.)

We stationers are having some difficulty making our customers understand this.

L. J. Messina,
Professional Printing Co.
New York, N.Y.

X-Ray Diagnosis

A New York Times editorial, criticizing a legislative proposal to bar X-ray technicians from making interpretations of films, was quoted not long ago in MEDICAL ECONOMICS. Here is a copy of a letter I wrote to the Times in reply to this editorial (it was never published):

"The editorial in the Times entitled 'X-ray and Medicine' is apparently based on misinformation.

[*Continued on page* 144]

Hay Fever Relief

often begins in 10 minutes

with a simple 6 gr. tablet of
NaCL, NH_4CL, KCL—nothing else.

OF course, you don't believe it and neither did we until we were confronted with repeated clinical proof and then for three years—repeated, increasing sales to doctors.

CHECK this tablet for yourself, as we have done and let results convince you.

IMPORTANT

The information given here is based on the reports of clinical tests in a large New York City Clinic and reports from physicians. As Manufacturing Chemists introducing Nakamo Bell we make no claim as to its usefulness or the correctness of the dosage given.

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Dr. .....

Address .....

"About twenty years ago the Department of Health of New York City put in force a regulation which required X-ray machines to be operated under the supervision of a doctor of medicine, a dentist, or 'other qualified person.' A chiropractor applied for a license, which was refused on the grounds that he was not qualified to practice medicine.

He sued the Department of Health, maintaining that he was a 'qualified person.' Eventually the case reached the Court of Appeals, which directed the Department of Health to give the chiropractor a license. The court undoubtedly made a correct statement of the legal point involved in the case: that the Department of Health had not defined a 'qualified person.'

However, the learned judges also made a statement to the effect that telling what is on an X-ray film is not making a diagnosis and is, therefore, not the practice of medicine. This *obiter dictum* had nothing to do with the legal question involved in the case, yet it has the force of law in the State of New York. At the present time, any individual can set up an X-ray laboratory and make X-ray examinations.

"X-ray methods are of profound importance in the diagnosis of many diseases. Often a physician is legally liable for negligence if he does not X-ray. The analysis of film requires a knowledge of the basic medical science of anatomy, physiology, and pathology, plus training in clinical medicine. It is quite true that certain fractures, for example, are easily detected; but others may be very difficult to detect even by doctors with years of experience.

"When Roentgen announced his

MAGNEPHYLLINE

(SHERMAN)

● Regardless of the etiological background, the immediate aim in the treatment of cardio-vascular diseases is prompt, safe relief from symptomatic distress.

Theophylline enjoys general acceptance as a myocardial stimulant but, due to its relative insolubility, it has been employed in practice in combination with strongly alkaline, soluble bases, with the result that nausea and gastro-intestinal irritation with distressing burning sensation have often attended its use.

Sherman Laboratories' research has developed a crystalline compound of theophylline and magnesium—MAGNEPHYLLINE—which provides all of the pharmacological action of theophylline plus a maximum of gastro-intestinal toleration, enabling the physician to reach the threshold of cardiac pain with larger doses when desirable, without excess of untoward side action.

MAGNEPHYLLINE represents 79% of theophylline and 5.36% magnesium in a small, relatively tasteless tablet.

Its use is indicated in cardiac decompensation, angina, sclerosis, thrombosis, hypertension and in some types of asthma.

Available in bottles of 20 and 100 tablets, on prescription or direct.

This booklet, descriptive of Magnephylline, with clinical references, mailed upon request.

SHERMAN LABORATORIES

G. H. Sherman, M. D., *Founder*

BIOLOGICALS • PHARMACEUTICALS

DETROIT, MICHIGAN

discovery in 1895, the importance of the X-ray in medicine was immediately seen. In some places this work was taken up by persons without medical training. The experience of two of them, who later paid the martyr's price, is worth noting. At the Massachusetts General Hospital in Boston, Walter James Dodd, a pharmacist, was assigned the job of running the crude X-ray machine. He soon saw the importance of medical training if he was to understand the significance of the shadows which appeared on his plates, and he went to medical school. Eugene Wilson Caldwell, the first X-ray specialist at the Presbyterian Hospital in New York, began to work with X-rays as an electrical engineer. He quickly realized his limitations and proceeded to study medicine. In recognition of his contributions, the American Roentgen Ray Society many years ago honored Caldwell by establishing an annual lecture in his name. The conclusions reached by these two intelligent men have been amply substantiated by subsequent experience. The medical profession has established radiology as one of the specialties.

"The American Board of Radiology was organized for the purpose of examining and certifying the qualifications of those doctors who wish to be recognized as specialists in this field. This board requires three years of specialized training in X-ray work in approved hospitals before it will admit a candidate for examination. At least six months of this time must be spent in studying pathology.

"If the medical profession re-

[*Continued on page* 150]

3 REASONS for Pragmatar's WIDE APPLICABILITY

1. Pragmatar is highly effective in an unusually wide range of common skin disorders, including eczema-dermatitis; seborrheic affections, especially of the scalp; fungous infections; psoriasis; etc.

2. In marked contrast to crude coal-tar ointments, it can, in most cases, be safely applied to any part of the body.

3. It is cosmetically superior—non-gummy; non-staining; easy to apply; easy to remove, even from hairy surfaces; and free from unpleasant odor.

Indications and detailed directions for the use of Pragmatar may be found in the "Manual of Dermatology", recently prepared and issued under the auspices of the Division of Medical Sciences of the National Research Council.

PRAGMATAR

(WITH SULFUR *and* SALICYLIC ACID)

A Significant Improvement in Tar-Sulfur-Salicylic Acid Ointments

SMITH, KLINE & FRENCH LABORATORIES, PHILADELPHIA, PA.

quires all this of a medical graduate, how can a medically untrained individual be expected accurately to tell what is on an X-ray film? Homer L. Sampson, D.Sc., is often mentioned as an example of achievement in X-ray diagnosis without medical training. He worked for many years in intimate collaboration with highly trained doctors who specialized in chest work at the Trudeau Sanitarium and had access to a great deal of carefully studied pathological material, so that he became skillful in the study of films of the chest.

"Your editorial makes a highly fallacious analogy between the staining of a microscopic slide of tuberculous sputum and the chemical determination of blood sugar, on one hand, and the analysis of an X-ray film on the other. Medical training is not necessary to recognize tubercle bacilli or to carry through chemical procedures for a blood sugar examination, but it most emphatically is necessary for an accurate analysis of the shadows on X-ray films or on the fluoroscopic screen in terms of normal anatomy of disease processes. The American Society of Registered X-ray Technicians recognizes this fact and requires each applicant for membership to pledge himself not to attempt to interpret X-ray films. The taking of X-ray films often requires a doctor's guidance, even when done by technicians of many years' experience. This fact is proved every day in the X-ray departments of good hospitals.

"The non-medical chemists, bacteriologists, and X-ray technicians play an important role in medical work, which is greatly appreciated by all physicians. Recognition of

To Relax the "Tetanic" Uterus

IN DYSMENORRHEA

Affords all the advantages of natural belladonna alkaloids —

YET IS SIGNIFICANTLY NON-TOXIC;

1

For dysmenorrhea of the spastic type, the employment of an effective antispasmodic commonly proves helpful in bringing relief of pain. In many cases, mild sedation also contributes materially to patient comfort. In Donnatal, the physician has a uniquely efficient "single-prescription" product for such therapy. For Donnatal provides a compound of *phenobarbital* with predetermined and controlled proportions of the *belladonna alkaloids*.

Provides for the sedation so frequently required —

YET IS ENTIRELY NON-NARCOTIC; AND

2

3

Has marked pharmacologic potency —

YET COSTS LESS

Available at about half the price of synthetic preparations, it actually costs less than tincture of belladonna and elixir of phenobarbital!

FORMULA: Each tablet contains belladonna alkaloids (hyoscyamine, atropine, and scopolamine) equivalent to approximately 5 min. tr. belladonna; plus ¼ gr. phenobarbital.

AVAILABLE: in bottles of 100 tablets.

A. H. ROBINS COMPANY, INC. · RICHMOND 19, VA.

DONNATAL

THE DEPENDABLE ANTISPASMODIC AND SEDATIVE

this fact, however, does not justify lax laws which permit ambitious or dishonest technicians to attempt practices for which they are not trained.

"An X-ray examination is always done in an attempt to make a diagnosis and is, in fact, part of the practice of medicine. For the protection of the people its use should be controlled by the laws which govern all other phases of medical practice."

Ross Golden, M.D.
Professor of Radiology,
Coll. of Phys. & Surg.
Columbia University,
New York, N.Y.

Trained Attendants

A news item in your June issue reported that a new nursing group made up of "trained attendants" would be trained for from nine to twelve months and licensed under the laws of Missouri to help relieve the shortage of registered nurses in that state. This report was in error; the new nursing class will be set up in Wisconsin. Missouri has not recently changed its nurse practice act.

Mary E. Stebbins, R.N.
Executive Secretary
Missouri State Nurses' Assn.
Kansas City, Mo.

Industrial Plan

The Union Health Center of the ILGWU, described in your article, "Clinic Care, Union Style," probably provides good medical attention at low cost, and apparently permits considerable freedom of choice. However, I feel it is not adequate for the average person because of its limited service. Few people like to consult one doctor when ambulatory and another when too ill to come to a clinic.

I have served for nine years as medical director of an industrial prepayment plan operated by a nonprofit association and sponsored by the Freeport Sulphur Co., Port Sulphur, La. Service is available at the Port Sulphur Hospital (a twelve-bed, well-equipped institution) or anywhere within a radius of ten miles of it.

The 1,500 members of the plan are employes of the sulphur company and their families. Each is eligible for all medical and surgical attention with the exception of specialists' services, X-ray, obstetrics, and major surgery. For these, reduced fees are charged (*e.g.*, an appendectomy—including surgeon's fee, assistant's fee, and anesthesia and operating room charges—costs $80.)

The plan is financed by monthly premiums of $2.50 for a family subscription and $1.50 for a single subscription. Two salaried physicians, who also conduct private practices, are always available.

The association operates at considerable loss and the company is obliged to subsidize it. The company originally invested $42,000 in the hospital (which the association

ONE ANSWER TO A DOCTOR'S DILEMMA . . .

THERE are any number of reasons why a woman "needs a corset." Advancing years, excess flesh, deterioration of the tone of the abdominal muscles . . . the practicing physician has seen them all many times. And today with increased physical burdens around the house and on the job, more and more women are consulting their doctors about the chronic fatigue, discomfort and other symptoms which result.

Problem—The doctor's problem is to give his patients the support they need and get them to follow his instructions. By and large, these women do not need restricting orthopedic belts and straps. They need support, freedom of action. But unless they also get a garment which is comfortable to wear and easy to put on, the chances are that they will not long wear it. Fortunately there is a garment which has all these advantages. It also has a feature that no other garment possesses. Before the patient even orders it, the doctor can be sure that she will get the support which he desires for her. The name of this garment is Spirella.

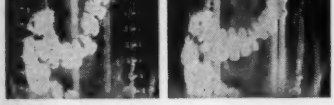
Natural Support—Spirella gives the necessary support together with a foundation around which proper posture habits can be relearned. Its action complements the normal action of the abdominal muscles with upward and backward traction. There is no unnatural constriction in the region of the diaphragm.

Comfortable—Spirella garments are comfortable to wear and easy to put on. And there is a notable improvement in the patient's appearance. Patients like to wear their Spirellas—and do wear them. The doctor can be confident his instructions will be followed.

Unique Method—These results could never be obtained through stock garments—no matter how wide the selection. They can only come from individually made garments. Which Spirellas are. Actually the secret lies in the way measurements are taken. As far as we know, the way Spirella does this is unique. The Spirella Corsetiere adjusts the exclusive Spirella Modeling Garment to the patient. This can be done in the doctor's presence so he can check the degree of support. He can even verify his observation by using the fluoroscope. Then measurements are taken of the supported figure and the patient's Spirella is individually made to exact specifications.

* * *

For complete information about Spirella natural support, write Dept. 7-3. The Spirella Company, Niagara Falls, N. Y. *In Canada*, address The Spirella Company, Ltd., Niagara Falls, Ontario.



X-Ray Evidence—That patient gets just the same natural support from her Spirella as she does from the Modeling Garment, whose adjustment was checked by the physician. These X-Rays were taken under competent medical supervision.

With the Spirella Modeling Garment adjusted (see left-hand X-Ray) the hepatic flexure lies 3½" above the iliac crest. The right-hand X-Ray shows the same woman in her individually designed Spirella. The hepatic flexure now lies 3⅝" above the iliac crest.

Thus, by suggesting Spirella garments, you can be sure of getting just the degree of support you want. In addition you can be sure that the patient will get exactly the same support in her finished garment.

leases for $1 a year) and is absorbing a monthly operating deficit of $525. Thus, in writing off the investment, the company meets a total monthly loss of about $1,500. Average cost per patient per day is $9 plus.

The plan as a whole is satisfactory, although there are numerous abuses. For one thing, too many patients too frequently consult physicians for very minor ailments, but this trend is curbed to some extent by the fact that such persons must pay for prescriptions.

It is evident that this type of plan will work to the benefit of both patient and physician if properly managed. We have found two things essential:

1. There must be some sort of control over the few unreasonable, chronically dissatisfied individuals who find their way into any organization. In our case membership is restricted to employes, who appreciate (and don't take advantage of) the company's willingness to underwrite losses in order to make good medical care available.

2. The plan must be able to support first-class doctors, nurses, and equipment. In our own organization, $2,400 a month is spent to care for 1,500 members.

B. H. Carlton, M.D.
Port Sulphur, La.

The Indigent

Raising the standards of indigent medical care is merely running around Robin Hood's barn. Let's raise the standards of the indigents by providing them with steady jobs. The unemployables present their own separate and distinct problem, which must be solved by the nation.

M.D., Wisconsin

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